SUBCOMMITTEE NO. 3 Agenda
Health, Human Services, Labor & Veteran's Affairs

Chair, Senator Elaine K. Alquist

Senator Alex Padilla
Senator Dave Cogdill

May 22, 2007

(May Revision Hearing)

10:00 AM

Room 4203

(Diane Van Maren)

Item	Department Listing
4265	Department of Public Health
4280	Managed Risk Medical Insurance Board
4260	Department of Health Care Services
4300	Department of Developmental Services
4400	Department of Mental Health
0530	CA Health & Human Services Agency

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. In addition: **(1)** All previous actions taken by the Subcommittee remain, unless the Subcommittee otherwise modifies the proposal at this May Revision hearing; **(2)** The "VOTE ONLY" CALENDAR for each department **may** include the modification or denial of proposals, as well as acceptance of proposals. This will be noted in the Agenda as applicable under the staff recommendation section.

I. ISSUES RECOMMENDED FOR "VOTE ONLY" *(Through to Page 20)*

A. Item 4280--Managed Risk Medical Insurance Board *(Vote Only)*

1. County Health Initiative Matching Fund (CHIM) Program (Issue 108)

Governor's May Revision. The May Revision reflects a decrease of $357,000 ($232,000 federal S-CHIP Funds and $125,000 in county funds) as a result of caseload and expenditure adjustments received from the county pilot projects (i.e., San Francisco, San Mateo, and Santa Clara), as well as an updated estimate for Santa Cruz which is slated to commence soon.

Background—County Health Initiative Matching Fund (CHIM) Program: AB 495, Statutes of 2001, allows county governments and public entities to provide local matching funds to draw down federal S-CHIP funds for their Healthy Kids Programs (i.e., children 250 to 300 percent of poverty who are citizens). The State Plan Amendment approved by the federal CMS provided for three pilot counties (i.e., San Francisco, San Mateo, and Santa Clara) with a phase-in of additional counties.

Subcommittee Staff Recommendation—Approve. This proposal reflects standard adjustments and no policy changes are being proposed. No issues have been raised.

B. Items 4260 & 4265 Health Issues (Both Departments) *(Vote Only)*

1. Adult Day Health Care –Technical Trailer Bill Language on Moratorium

Issue. The Subcommittee is in receipt of a constituent letter requesting a technical amendment to existing state statute regarding the ongoing moratorium for Adult Day Health Care (ADHCs). As noted in the background section below, the moratorium has been in effect since 2005, with some minor adjustments agreed to by the Administration.

One of the exceptions to the moratorium that had been agreed to with the Administration pertains to a site located in Eureka that will be ready for occupancy in 2008. In order for this facility to proceed, as had been the intent, a technical data reference needs to be added to existing statute to enable the Department of Health Care Services to proceed with its licensing field survey in 2008. **The proposed amendment is shown below:**

Section 14043.46 (b) is amended to as follows (underline):

> (6) An applicant that is requesting expansion or relocation, or both that has been Medi-Cal certified as an adult day health care center for at least four years, is expanding or relocating within the same county, and that meets one of the following population-based criteria, as reported in the California Long Term Care County Data Book, 2002:
>
> (A) The county is ranked number one or two for having the highest ratio of persons over 65 years of age receiving Medi-Cal benefits.
> (B) The county is ranked number one or two for having the highest ratio of persons over 85 years of age residing in the county.
> (C) The county is ranked number one or two for having the greatest ratio of persons over 65 years of age living in poverty.

Background—What Are Adult Day Health Care Services. Adult Day Health Care (ADHC) is a community-based day program providing health, therapeutic and social services designed to serve those at risk of being placed in a nursing home. The ADHC Program is funded in the Medi-Cal Program. The DHS performs licensing of the program and the Department of Aging administers the program and certifies each center for Medi-Cal reimbursement. The baseline budget for the ADHC Program is $375.8 million ($187.9 million General Fund). The average monthly cost per ADHC user is $931.11. The projected average monthly user of these services is 33,633.

The current reimbursement rate for ADHCs is 90 percent of the nursing facility level A rate. This is a bundled, all-inclusive rate for all ADHC services which was set by a court settlement in 1993. The budget assumes a 4.35 percent rate increase for these services as well which corresponds to existing law.

The bundled reimbursement rate pays for a day of ADHC services (defined as a minimum of four hours, not including transportation) regardless of the specified services actually provided on any given day. The bundled rate assumes that the required ADHC services will be provided to individuals as deemed medically necessary.

Background—Moratorium Continues on New ADHC. Through the Budget Act of 2004 and accompanying trailer bill legislation, a 12-month moratorium on the certification of new ADHCs became effective. This was done to diminish the growth of the centers due to concerns regarding rapid growth and the potential for Medi-Cal fraud, as well as concerns expressed by the federal CMS regarding the operation of California's program (which SB 1775, Statutes of 2006 address). With minor adjustments, this moratorium was extended for 2005 and 2006, and the budget assumes this continuation through 2007-08. Existing statute makes annual renewal of the moratorium the purview of the Director of Health Services (Director Sandra Shewry).

Subcommittee Staff Recommendation—Adopt Trailer Bill Amendment. It is recommended to adopt a technical amendment to Section 14043.46(b) of the Welfare and Institutions Code, as shown above, to ensure that appropriate data is being used for determining the continuation of the Adult Day Health Care moratorium.

Though this is not an Administration sponsored change, the Department of Health Care Services is supportive of the clarification in statute.

2. Genetic Disease Testing Program (Issue 624)

Prior Subcommittee Hearing. In the March 12th hearing, the Subcommittee discussed this program and approved the January budget. The Administration has received updated information that has resulted in a May Revision change.

Governor's May Revision Issue. The May Revision proposes total expenditures of $118.3 million (Genetic Disease Testing Fund) in local assistance for the Genetic Disease Testing Program. This reflects a minor overall reduction of $526,000 (Genetic Disease Testing Fund) for the Newborn and Prenatal Screening Programs resulting from a decrease in system development and equipment expenditures, and increases in reagent costs and the number of infants requiring Newborn Diagnostic Services.

Background—What is the Genetic Disease Testing Program? The Genetic Disease Testing Program consists of two programs—the Newborn Screening Program and the Prenatal Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided as part of the fee payment. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers or private parties using a special fund—Genetic Disease Testing Fund.

The Newborn Screening Program provides screening of *all* newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $103 dollars. Where applicable, this fee is paid by the family's insurance, the Medi-Cal Program, or out-of-pocket.

The Prenatal Screening Program provides screening of pregnant women who consent to screening for serious birth defects. The fee paid for this screening is $162 dollars. Where applicable, this fee is paid by the family's insurance, the Medi-Cal Program, or out-of-pocket.

Subcommittee Staff Recommendation--Approve. No issues have been raised regarding the May Revision. It is recommended to approve it as proposed.

3. Child Health Disability Prevention (CHDP) Program (Issue 622)

Governor's May Revision. The May Revision proposes total expenditures of $2.8 million ($2.7 million General Fund) for this program which reflects a *decrease* of $209,000 (General Fund) as compared to January. This minor reduction is due to standard caseload and utilization of services adjustments. No policy changes are proposed.

Overall Background. The Child Health Disability Prevention (CHDP) Program provides pediatric prevention health care services to **(1)** infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and **(2)** children and adolescents who are eligible for Medi-Cal services up to age 21 (Early Periodic Screening Diagnosis and Treatment—EPSDT).

Children in families with incomes at or below 200 percent of poverty can pre-enroll in fee-for-service Medi-Cal under the presumptive eligibility for children provisions of the Medi-Cal and Healthy Families programs. This pre-enrollment takes place electronically at CHDP provider offices at the time the children receive health assessments. This process, known as the CHDP Gateway, shifts most CHDP costs to the Medi-Cal Program and to Healthy Families. As such, CHDP Program funding needs to continue only to cover services for children who are eligible for limited-scope Medi-Cal benefits (such as immunizations).

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health examination certificate or an equivalent examination to enroll in school. Local health jurisdictions work directly with CHDP providers (private and public) to conduct planning, education and outreach activities, as well as to monitor client referrals and ensure treatment follow-up.

Subcommittee Staff Recommendation--Approve. No issues have been raised regarding this proposal. It is recommended to approve as proposed.

4. Genetically Handicapped Persons Program (GHPP) (Issue 623)

Governor's May Revision Issue. The May Revision proposes total expenditures of $49.5 million for an increase of $160,000 (increase of $12.7 million General Fund, reduction of $3 million in Rebates and a reduction of $9.5 million in federal funds) as compared to the January budget.

Of the proposed increase to the General Fund, $9.5 million is due to a fund shift that is changing. Previously, the Administration was using federal funds, which are available through the state's Medicaid Waiver for Hospital Financing (the safety net care pool funding), to backfill for General Fund support. In the May Revision, the Administration will no longer be applying this fund shift to this program, but instead, will be applying it to the Medi-Cal Program. As such, there is no overall General Fund increase attributable to this fund shift.

The May Revision does reflect a reduction of $3 million in special Rebate Fund moneys which were to be available under the program and now will not be captured in 2007-08. As such, General Fund support was needed to backfill for this loss in special funds.

No policy changes are proposed for the program.

Overall Background: The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially ineligible for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

Subcommittee Staff Recommendation--Adopt: It is recommended to **adopt the May Revision** as proposed.

5. California Children's Services (CCS) Program (Issue 621)

Governor's May Revision Issue: The May Revision proposes total expenditures of $234.7 million ($96.4 million General Fund) which reflects an overall decrease of $3 million (increase of $37.9 million General Fund, decrease of $40.9 million federal funds). These decreases are due to a series of adjustments and do not reflect any policy changes.

Of the proposed increase to the General Fund, $37.3 million is due to a fund shift that is changing. Previously, the Administration was using federal funds, which are available through the state's Medicaid Waiver for Hospital Financing (the safety net care pool funding), to backfill for General Fund support. In the May Revision, the Administration will no longer be applying this fund shift to this program, but instead, will be applying it to the Medi-Cal Program. As such, there is no overall General Fund increase attributable to this fund shift.

Overall Background on CCS: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible, and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as county funds.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

6. Program for All-Inclusive Care for the Elderly (PACE)

Issue. Constituency groups have raised concerns with the current status of the Program of All-Inclusive Care for the Elderly (PACE) in California. Specifically, nonprofit organizations who have invested resources to develop a PACE Program are delayed and have no assurance that their applications will be processed and approved by the Department of Health Care Services in a timely manner.

According to the National PACE Association, over 65 organizations in California have inquired about developing a PACE. At a minimum, all of the existing PACE providers, as noted below, want to expand their existing programs. According to recent information from the DHS, there are at least ten organizations that have indicated recent interest in PACE and the Los Angeles Jewish Homes for the Aging is expected to submit an application within a few months.

The DHS notes that they have crafted a comprehensive PACE implementation work plan to provide for more efficient reviews of PACE applications and to increase the number of PACE programs operating in the state. However, they have not come forth with any additional resources in order to implement these efforts.

Through the Budget Act of 2001, the Legislature provided $200,000 ($100,000 General Fund) for additional DHS staff to process PACE applications but this was vetoed by the Governor. Through the Budget Act of 2002, the Legislature again provided $200,000 ($100,000 General Fund) for additional DHS staff but the DHS was unable to fill the positions in a timely manner and the funds were swept as part of a reduction to state administration. Through the Budget Act of 2005, the Legislature again provided $200,000 ($100,000 General Fund) for the two positions; however, these two positions expire as of June 30, 2007.

Background—What is PACE. PACE providers integrate all Medicaid (Medi-Cal) and Medicare funding and services so that older individuals in need of long-term care can continue living in the community. PACE coordinates the care of each participant enrolled in the program based on individual needs.

PACE provides comprehensive medical and long-term care services, with the program's interdisciplinary team (physicians, nurse practitioners, nurses, social workers, therapists, van drivers and others) fully coordinating these services. PACE programs receive monthly capitated payments from Medicare, Medi-Cal and private individuals depending on the individual's eligibility for public programs.

To be eligible for PACE, an individual must: (1) be 55 years of age or older; (2) be certified by the state to need nursing home care; (3) reside in the service area of the PACE organization; and (4) be able to live in a community setting without jeopardizing his/her health or safety.

California presently has four approved PACE providers that have 13 PACE centers in different low-income communities, serving 1,700 seniors. The PACE programs include: (1) On Lok in San Francisco; (2) Center for Elders Independence in Oakland; (3) Sutter

SeniorCare in Sacramento; and (4) AltaMed Health Services Corporation in Los Angeles.

PACE receives a capitated Medi-Cal rate, as well as Medicare rate. The Medi-Cal capitated rate provides the state with a 10 percent savings relative to its expenditures for a Medi-Cal nursing home population. PACE programs have full financial risk for services including nursing home placement if participants need this service.

Subcommittee Staff Recommendation—Provide Resources. It is recommended to increase by $200,000 ($100,000 General Fund) to support two Associate Governmental Program Analyst positions to facilitate application review processes for the PACE Program and to proceed with the DHS' work plan regarding the PACE Program. This action would conform to the Assembly Subcommittee #1 action.

7. Technical Adjustment for Department of Public Health (Issue 620)

Governor's May Revision. The May Revision contains a technical adjustment regarding the establishment of the Department of Public Health (DPH). It proposes to increase federal fund authority by $8.258 million within the DPH to recognize receipt of federal grant funds received under the Refugee Resettlement Program. These funds were inadvertently not captured by the Administration while it was crafting the DPH budget.

The DPH will receive these federal grant funds and will in turn provide the Department of Health Care Services (DHCS) these funds via an interagency agreement to pay for health care services for new refugee arrivals in the state.

This arrangement is necessary because the DPH has administrative authority over the entire Refugee Health Assessment Program, and the federal government will only allow one grant award for refugee health services in the state. As such, the DHCS will invoice the DPH for Medi-Cal expenditures as appropriate. The DHCS estimates that Medi-Cal expenditures for refugee arrivals will be about $5.6 million in 2007-08. The remaining federal grant funds are then used by the DPH for other related purposes.

Subcommittee Staff Recommendation—Approve. It is recommended to approve this proposal. It is a technical budget correction to recognize the receipt of the federal grant funds by the DPH. These grant funds have been ongoing.

8. Reappropriation of Three Public Health Programs (Issue 364)

Governor's May Revision. The May Revision proposes reappropriation language for three public health programs**—(1)** the Infant Botulism Treatment & Prevention Fund; **(2)** the Proposition 50 Water Security, Clean Drinking Water, Coastal and Beach Protection Fund of 2002; and **(3)** the Vital Records Image Redaction and Statewide Access Project. Both of these funds are special funds. The General Fund is not affected by the proposal.

The proposed reappropriation language would enable the Department of Public Health to expend Infant Botulism Treatment and Prevention Funds from 2006 through June 30, 2008.

For the Proposition 50 Bond Funds for water projects, it would provide reappropriation authority through until June 30, 2008 for certain funds, and through June 30, 2009 for other funds as noted in the language below.

For the Vital Records Image Redaction and Statewide Access Project (VRIRSA), it would provide reappropriation authority through 2008.

The proposed reappropriation language is as follows:

> **Infant Botulism Treatment and Prevention Fund**
> (1) Item 4260-001-0272, Budget Act of 2006 (Chapters 47 and 48, Statutes of 2006). Funds appropriated in this item for the Infant Botulism Treatment and Prevention Program are available for expenditure during **2007-08 fiscal year**, subject to the provisions of that appropriation.
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> **Water Security, Clean Drinking Water, Coastal and Beach Protection Fund of 2002 (Proposition 50 Bond Funds)**
> (1) Item 4260-111-6031, Budget Act of 2005 (Chapters 38 and 39, Statutes of 2005). Funds appropriated in this item for the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 are available for expenditure during **2007-08 fiscal year**, subject to the other provisions of that appropriation.
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> (2) Item 4260-115-6031, Budget Act of 2005 (Chapters 38 and 39, Statutes of 2005). Funds appropriated in this item for the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 are available for expenditure during **2007-08 fiscal year**, subject to the other provisions of that appropriation.
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> (3) Item 4260-111-6031, Budget Act of 2006 (Chapters 47 and 48, Statutes of 2006). Funds appropriated in this item for the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 are available for expenditure during **2007-08 and 2008-09 fiscal years**, subject to the other provisions of that appropriation.
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> (4) Item 4260-115-6031, Budget Act of 2006 (Chapters 47 and 48, Statutes of 2006). Funds appropriated in this item for the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 are available for expenditure during **2007-08 fiscal year and 2008-09 fiscal years**, subject to the other provisions of that appropriation

Vital Records Image Redaction and Statewide Access Project
(1) Item 4260-001-0099, Budget Act of 2006 (Chapters 47 and 48, Statutes of 2006). funds appropriated in this item for the VRIRSA and the related computerization of vital records are available for expenditure during the 2007-08 fiscal year, subject to the provisions of that appropriation.
(2) Item 4260-111-0099, Budget Act of 2006 (Chapters 47 and 48, Statutes of 2006). Funds appropriated in this item for the VRIRSA are available for expenditure during the 2007-08 fiscal year, subject to the provisions of that appropriation.

Background—Infant Botulism. The DHS has an "orphan drug" license from the federal FDA for the Botulism Immune Globulin Intravenous (Baby BIG) which is the only antidote available for infant botulism in the world for infants. The licensure was provided by the federal FDA in 2003 but prior to that, the DHS provided the drug for many years. Baby BIG is made by harvesting and bottling special antibodies from the blood plasma of volunteer donors. Without treatment, affected infants spend weeks to months in the hospital, much of that time in intensive care. About 100 cases occur in the United States per year.

In the Budget Act of 2006, $1.1 million in one-time expenditure authority was provided so that the manufacture of this drug could be transferred from the Massachusetts Biologic Laboratory to a replacement manufacturer. Delays in this transfer have occurred for various reasons. Reappropriation language is requested for the unspent funds to make the next lot of Baby BIG as required.

Relocation activities are continuing and a new manufacturer has now provided the DPH with a letter of intent committing to do the work and contract language has been negotiated and developed.

Background—Proposition 50 Bond Funds for Water Systems. As discussed previously in the Subcommittee, the DPH is to receive a total of $485 million from Proposition 50 of 2002, the Water Security, Clean Drinking Water, Coastal and Beach Protection Act. These funds are comprised of the following: (1) $50 million from Chapter 3 of the Act which is for protecting water systems from terrorist attack or deliberate acts of destruction; and (2) $435 million for grants and loans for public water system infrastructure improvements and related actions to achieve safe drinking water standards.

Proposition 50 appropriation authority is provided annually through the Budget Act. This requires the funds to be encumbered during the year of appropriation and for the work to be performed in the same year, with an additional two years to liquidate.

The DPH notes that water construction projects can take as long as five to seven years to complete and all work is paid for on a reimbursement basis (no up front grants). Due to the many differences in water systems progressing to funding agreement, construction scheduling and progress, it is not possible to predict with accuracy the timing of when the work will be performed and invoices submitted. Therefore, reappropriation authority is needed to compensate for the timing issue between when the work is performed and when the DPH is invoiced for payment. The DPH states that this will allow appropriation authority to keep up with cash flow needs.

Subcommittee Staff Recommendation—Approve. The reappropriation language would provide for an extended period of expenditure for certain special funds as noted. Due to the nature of the two programs, it seems reasonable to approve the proposed reappropriation. No issues have been raised.

9. Administration's Proposal to Move the Fresno Medi-Cal Field Office

Issue. As part of an ongoing effort to streamline and consolidate its Medi-Cal field offices, Department of Health Care Services (DHCS) plans to close its office in Fresno in 2007-08 and relocate some staff and operations to its Sacramento field office. Currently, the Fresno field office has 41 staff. The department estimates that 10 would relocate to Sacramento and 15 would be retained in the Fresno area and continue to handle "on-site" hospital treatment authorization requests (TARs) and medical case management locally, but without a physical office structure. The department assumes that the remaining 16 positions would either decline to relocate or be vacant at the time of the move.

Medi-Cal currently operates six field offices—San Diego, Los Angeles, San Bernardino, San Francisco, and Sacramento, in addition to Fresno. These offices process TARs, which are pre-authorizations that providers must obtain for certain services in order to receive payment from Medi-Cal and they house medical case management staff. County social services offices handle Medi-Cal eligibility and enrollment.

The Fresno office is in a state building that will be undergoing renovation soon to address a number of ongoing problems (part of the stated reason for relocation). For this reason, temporary relocation of the Fresno office (within the Fresno area) would be required in any case.

Projected Costs and Savings. The department estimates a net *cost* of $96,000 to relocate to Sacramento in 2007-08 (versus temporary relocation within Fresno) and then net savings of $761,000 over a five-year period. General Fund cost and savings would be half of these amounts.

Actual State Savings Unlikely. The department's projected ongoing savings are small, and relocation would leave remaining staff in Fresno to work out of their homes. However, even these projected savings appear ephemeral from a statewide point of view. Discussions with the Department of General Services (DGS) indicate that there are unlikely to be any state savings by relocating the Fresno Medi-Cal field office.

DGS has not identified a tenant to occupy the space to be vacated by Medi-Cal. In the near term, DGS plans to use the space as "swing space" for the remaining state agency tenants during the renovation of the facility, but after that, it is likely that the space will remain vacant. DGS will have to make up for the loss of the revenue by increasing the rental rates for all state office buildings. In contrast, there are a multitude of potential state agency tenants for the Sacramento relocation site (the East End Project).

Subcommittee Staff Recommendation—Reject Fresno Move and Adopt Budget Bill Language. It is recommended to adopt the following Budget Bill Language to maintain the Fresno Field Office. This action would conform to the Assembly. The proposed language is as follows (Item 4260-001-0001):

> "No funds appropriated or scheduled in this item may be used to relocate the Fresno Medi-Cal Field Office outside of the Fresno area or to close the office. The department may temporarily relocate the field office within the Fresno area if necessary to accommodate the renovation of the Fresno facility."

10. Medicare Part D Emergency Drug Coverage Program

Governor's May Revision. Assembly Bill 132 (Nunez), Statutes of 2006, provided emergency drug coverage for individuals eligible for both the Medi-Cal and Medicare programs (dual eligibles) through to January 31, 2007. The purpose of this program was to serve as a safety-net transition for dual eligibles to the federal Medicare Part D Drug Program while problems with the federal program were being remediated.

The May Revision identifies an additional $7.4 million in unexpended General Funds which were appropriated for this legislation. These unexpended funds are in addition to the $80 million in unexpended General Funds that the Governor's January budget already captured. It should be noted that these unexpended General Fund resources were determined by the Administration to be unnecessary since the enabling legislation expired and all reimbursements have been paid for the current-year.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the May Revision. No issues have been raised. The statutory authorization has ended.

11. Medi-Cal Program--Two State Staff for County Performance Measures

Prior Subcommittee Hearing and Issue. In the April 16th hearing, the Subcommittee discussed the Administration's trailer bill language to increase from 90 percent to 95 percent the Medi-Cal Program's county performance standards.

In addition, the Subcommittee rejected the Administration's request to increase by $195,000 ($97,000 General Fund) to support two Associate Medi-Cal Eligibility Analysts to *maintain* oversight of this county performance measure system. Presently, these two positions are set to expire as of June 30, 2007.

Subcommittee Staff Recommendation—Approve the Two Positions. It is now recommended to increase by $195,000 ($97,000 General Fund) to support the two positions. The Administration has provided additional information regarding these positions since the April 16th hearing. Specifically, the positions are needed to continue the existing reviews of the counties. According the DHCS, these positions, along with two other existing positions, are needed to: (1) review 50 counties; (2) evaluate 21 counties for their applications processing; and (3) interact with counties regarding corrective action plans. It should also be noted that the two positions are presently filled.

The trailer bill language regarding this issue is discussed separately under the Department of Health Care Services, below.

C. Item 4440 Department of Mental Health *(Vote Only)*

1. Governor Proposes Elimination of the Integrated Services for Homeless Mentally Ill Program (Assembly Bill 2034 (Steinberg), Statutes of 2000)

Prior Subcommittee Hearing. In the March 12th hearing, the Subcommittee discussed the Governor's January proposal to eliminate the Integrated Services for Homeless Mentally Ill Program administered by the Department of Mental Health for a reduction of $54.9 million (General Fund).

During the Subcommittee deliberations, it was noted how cost-effective this program is to the state and local communities where it operates, and how the Governor's proposal likely violates the purposes of Proposition 63—the Mental Health Services Act—as passed by the voters in 2004, because it reduces the state's baseline funding for mental health services which the Proposition requires the state to maintain.

The Administration noted that AB 2034 projects are efficacious and serve as the principle model for the design of Proposition 63—the Mental Health Services Act—of 2005. They stated that their reduction is proposed solely for the purpose of reducing General Fund, and intimated that Proposition 63 funds could possibly be used by local communities for this purpose.

The Subcommittee placed $54.9 million (General Fund) on to the Subcommittee's "checklist" to potentially fund at the May Revision.

Background—Integrated Services for Homeless Mentally Ill Program (See Hand Out). This is a competitive grant program that provides state General Fund support to counties. The enabling legislation was adopted on a bipartisan basis. Presently, 34 counties receive grants that total $54.9 million. The program has been independently evaluated on several occasions and has had measurable outcomes as noted below:

- 56 percent reduction in the number of days hospitalized;
- 72 percent reduction in the number of days incarcerated;
- 67 percent reduction in the number of days spent homeless;
- 65 percent increase in the number of days employed full-time; and
- 280 percent increase in the number of individuals receiving wages.

The average cost per individual served is $12,000 annually.

Background—Proposition 63 (Mental Health Services Act). The Mental Health Services Act addresses a broad spectrum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The Act imposes a one percent income tax on personal income in excess of $1 million. The

total resources available in the Mental Health Services Account are $3 billion for 2006-07 and $4.3 billion for 2007-08. Of this amount, the Governor's budget proposes total expenditures of $517.9 million for 2006-07 and $1.5 billion for 2007-08, most of which is for local assistance.

Among other things, the Act requires these funds to be used to supplement and not supplant existing resources. The clear intent of the Act is to expand mental health funding.

Subcommittee Staff Recommendation—Appropriate $54.9 million. It is recommended to augment by $54.9 million (General Fund) to restore funding to the Integrated Services for Homeless Mentally Ill Program and thereby, reject the Governor's proposal to eliminate this important and cost-beneficial program.

2. Implementation of the *Conlan* Court Order (Medi-Cal Recipients) (issue 403)

Governor's May Revision. The Governor's May Revision proposes reappropriation language for the unencumbered balance of the $3.318 million ($1.6 million General Fund) as appropriated in the Budget Act of 2006 to comply with the requirements of the *Conlan* Court Order (*Conlan v. Shewry*). The reappropriation language would enable the DMH to spend these funds through June 30, 2008.

The DMH states that the reappropriation is needed because the court did not approve the Department of Health Care Services (DHCS) revised Plan until November 16, 2006 and letters to Medi-Cal beneficiaries were sent out from December to February 2007 but claims have not yet been submitted as was expected.

The $3.318 million originally appropriated in the Budget Act of 2006 equates to one-half of the total estimate of retroactive and co-pay claims. In addition, the DMH is contracting with Electronic Data Systems (EDS) to process and pay the DMH *Conlan* claims. The DMH states that about $761,000 (General Fund) will be spent in the current year for planning and setting up procedures, including labor costs, for this process.

The DMH must process claims from Medi-Cal beneficiaries who had unreimbursed expenditures for medical expenses **(1)** during the three-month period prior to applying for Medi-Cal benefits if determined eligible during that period, **(2)** during the period that an application for Medi-Cal was pending, and **(3)** during the period between a denial of their application for eligibility and reversal of that decision. In addition, it also applies to Medi-Cal beneficiaries with other health coverage that erroneously paid excess co-payments to a provider.

Background—*Conlan vs. Shewry*. Several departments are affected by this Department of Health Care Services lawsuit. This lawsuit has a long history resulting in the issuance of several court decisions.

To effectively implement the court ordered requirements of Conlan, the DMH must process claims from Medi-Cal beneficiaries who paid out-of-pocket expenses for Medi-Cal covered services received during specific periods of a beneficiary's Medi-Cal eligibility. **These periods include: (1)** the retroactive eligibility period (up to 3 months prior to the month of application to the Medi-Cal Program); **(2)** the evaluation period (from the time of application to the Medi-Cal Program until eligibility is established); and **(3)** the post-approval period (the time after eligibility is established).

The court has approved the DHCS revised implementation plan which was effective as of November 16, 2006. As a result of this plan, about 12 million letters were sent to households in December 2006. Letters were sent to all Medi-Cal beneficiaries who had applied and were eligible at some point on or after June 27, 1997.

Subcommittee Staff Recommendation--Approve. It is recommended to approve the reappropriation in order to ensure that funds are available for any claims as required by the court order.

3. San Mateo Pharmacy and Laboratory Services Project

Prior Subcommittee Hearing. In the April 30th hearing, the Subcommittee adopted two pieces of language to require the DMH to **(1)** comprehensively report back to the Legislature regarding the policy implications of the project, and **(2)** provide the Legislature, by no later than September 1, 2006, with their action plan to implement fiscal reforms regarding the San Mateo Pharmacy and Laboratory Services Project.

Fiscal issues regarding the San Mateo Project were left "open" pending receipt of the Governor's May Revision.

Issue. The Administration **is proposing two fiscal adjustments for the San Mateo Pharmacy and Laboratory Project (San Mateo Project).** In addition, the Office of State Audits and Evaluations (OSAE), within the Department of Finance, is in the process of conducting a review of the San Mateo Project, including the forecasting methodologies used to project costs as well as the claims processing system for state reimbursement. Each of these issues is discussed below.

First, a deficiency appropriation of $8.7 million (General Fund) is requested for prior year obligations (from 2004-05 and 2005-06). This request is tied to the accounting error that occurred between the DMH and the Department of Health Services (DHS) which was discussed in the Subcommittee's March 12th hearing as it pertained to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Unfortunately, the error also affected the San Mateo Project.

Specifically when the Medi-Cal Program, administered by the DHS, shifted to a cash-based accounting system, the DMH did not make adjustments in its programs to appropriately account and budget for this change. As such, the DMH is requesting the $8.7 million General Fund increase to fund prior year obligations as noted.

Second, the DMH is seeking a technical baseline adjustment to reflect a reduction of $139,000 (General Fund) from the current year (2006-07) and a related adjustment of $231,000 ($139,000 General Fund) for the budget year (2007-08). No concerns have been raised regarding this adjustment.

Background—What is the San Mateo Project? The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Medicaid (Medi-Cal) Waiver agreement and state statute since 1995. This "field test" was enacted into state law to allow the DMH to test managed care concepts in support of an eventual move to a capitated or other full risk model for the delivery of Medi-Cal specialty mental health services.

Effective July 1, 2005, the San Mateo Project was modified but it continues to cover pharmacy and related laboratory services, in *addition* to the required Mental Health Managed Care services that other County Mental Health Plans provide. San Mateo is the only county that has this added responsibility.

The San Mateo Project is funded at $8.8 million ($4.4 million General Fund and $4.4 million

federal funds) for 2007-08.

Subcommittee Staff Recommendation--Approve. It is recommended to approve the January budget request as proposed.

4. Various Adjustments for the State Hospital System (Issues 206, 208, 209 & 210)

Governor's May Revision. The May Revision proposes several adjustments for the DMH administered State Hospital system that pertain to program operations and support. **These issues are as follows:**

- *Hospital Peace Officers for Visitor Center at Patton.* An increase of $312,000 (General Fund) to support five Hospital Peace Officers to provide security for the visiting room at Patton State Hospital is requested. The DMH states that by proving these positions, the CA Department of Corrections and Rehabilitation (CDCR) will be able to redirect the existing five Correctional Officers in the visiting room to provide needed medical transport and escort services of penal code patients. Patton's patient population has experienced a substantial increase in medical appointments that require transportation to outside medical facilities. The CDCR is presently required to provide these transport services. The DMH states that because of the shortage of CDCR officers for transport, Patton patients have had 122 medical appointments cancelled, or 6.8 percent, due to not having CDCR officers available for this purpose. If State Hospital patients are not receiving timely medical treatment, it places the hospital at risk of being in violation of the U.S. Department of Justice CRIPA Agreement (as discussed in the March 12th hearing).

- *Prison Industry Authority Laundry & Transportation Cost Increase.* The May Revision proposes an increase of $164,000 (General Fund) to reflect higher costs for transportation and laundry services provided by the Prison Industry Authority.

- *Staff for Atascadero State Hospital Multi-Purpose Building.* The May Revision proposes an increase of $200,000 (General Fund) to support four positions, including two Custodians, a Groundskeeper, and an Associate Information Systems Analyst to support the new multi-purpose building at Atascadero State Hospital. The DMH states that this new building will serve as a critical location in the hospital to provide state-of-the-art wellness and recovery treatment services in a therapeutic milieu, centralized resources for patient's use, and office space for staff. It will be used to provide required treatment space for up to 1,259 patients per day and will be used by large numbers of treatment providers. The Associate Information Systems Analyst will be responsible for all computers and information technology equipment in the area for both patients and staff. The other positions are needed to maintain the facility. No request for staff was attached to the project previously.

- *Coalinga State Hospital Project.* An increase of $450,000 (General Fund) is requested for a digital document management retrieval system and consultant services at Coalinga State Hospital in 2007-08 for the purchase of document software ($150,000), hardware

(servers and scanners at $100,000) and consultant services for implementation and training. This information technology project was included in the current year budget but the project has been shifted to the budget year. The revised current year reflects a reduction of $608,000 (General Fund) due to this shift. This project is needed to manage the SVP document processing at Coalinga State Hospital.

Subcommittee Staff Recommendation—Approve. It is recommended to approve these adjustments for the State Hospitals. No issues have been raised.

II. ISSUES FOR DISCUSSION

A. Item 4265 Department of Public Health *(Discussion Items)*

1. AIDS Drug Assistance Program & HIV/AIDS Program Adjustments (Issue 358)

Prior Subcommittee Hearing. In its April 16th hearing, the Subcommittee approved the Office of AIDS funding proposal for the AIDS Drug Assistance Program. However, based on revised data, the Administration is proposing a May Revision change to the program.

Governor's May Revision. The May Revision is proposing a series of adjustments to several programs which provide assistance to people living with HIV infection and AIDS.

First, adjustments are proposed for the AIDS Drug Assistance Program (ADAP). These funding adjustments are shown in the table below and result in a *net* reduction of $10.5 million (total funds) for total expenditures of $288.9 million for 2007-08 ($90.6 million General Fund). The Office of AIDS states that the net reduction to the ADAP is due to a number of efficiencies which have been implemented.

AIDS Drug Assistance Program (ADAP)--Governor's May Revision

Fund Source	January 2007-08	May Revision 2007-06	Difference *(rounded)*
General Fund	$107.650 million	$90.565 million	-$17.1million
Federal Funds	$100.905 million	$90.375 million	-$10.5 million
Drug Rebate	$90.833 million	$107.918 million	+$17.1 million
TOTAL	**$299.388 million**	**$288.858 million**	**-$10.5 million** (Rounded Net Reduction)

As shown in the table above, in addition to the reduction, the May Revision also proposes a *shift* in funding sources to obtain General Fund savings of $17.1 million. AIDS Drug Rebate Fund support will be used in lieu of General Fund. The available rebate authority in the AIDS Drug Rebate fund is the result of a very efficient rebate collection process, and the Office of AIDS involvement in national efforts to collect rebates from anti-retroviral manufacturers. This fund shift still leaves about $13 million in reserve in the AIDS Drug Rebate Funds. This provides for a prudent special fund reserve. **No issues have been raised regarding the reduction or the fund shift. The ADAP is to be fully funded.**

Second, the Office of AIDS is proposing to utilize the savings from ADAP-- the $17.1 million in General Fund support and $10.5 million in federal funds-- in several ways. It should be noted that in order for California to maintain its federal "maintenance of effort" (MOE) requirements, no more than $7.3 million of the General Fund savings can be recognized as savings and utilized for *non-AIDS* related programs. Otherwise the state's federal Ryan White CARE Act funds of $122 million are jeopardized.

- **$17.1 million in General Fund savings would be allocated as follows on a *one-time* only basis**:

o *$4.0 million for the Therapeutic Monitoring Program (TMP)*. The TMP is presently funded at $4 million (General Fund) and this one-time only addition would increase it to $8 million for 2007-08. Under this program viral load and resistance testing is done to measure the degree to which an individual's HIV has become resistant or less sensitive to anti-retroviral drugs. About 15,000 clients accessing TMP services are enrolled in ADAP. The TMP is important in order to ensure that ADAP drugs are used in the most efficient manner.

o *$1.5 million for the AIDS Regional Information and Evaluation System (ARIES).* ARIES is a web-based case management system which is used to support client access to care and treatment and will replace several outdated data collection systems. The Office of AIDS states that AREIS provides a cost-effective process for federal reporting, an increased ability to oversee service utilization, helps to coordinate care for shared clients, and ensures the provision of appropriate services. These funds would be used to support statewide implementation and training for ARIES.

o *$500,000 for Capacity Building.* These funds would be used to develop curricula for an "AIDS Institute" within the Office of AIDS that would provide statewide training and technical assistance in identifying alternative assistance through third-party payers, HIV transmission reduction, HIV disclosure assistance, linking newly tested HIV-positive persons into care and treatment programs, and related functions.

o *$1.8 million for Six "Eligible Metropolitan Areas.* There are six areas within California that will be losing federal Title I Ryan White CARE Act funds due to changed federal formulas. These areas are home to almost 30 percent of California's HIV population and are integral to the overall service system within California. These funds would be used to help mitigate the loss of federal funds in 2007-08. The six areas include: Orange; San Bernardino/Riverside; Sacramento; Santa Clara; Sonoma; and Contra Costa/Alameda.

o *$2.0 million for the HIV/Names Reporting.* These funds would be used to provide funding for the first year of the three year assistance to be provided to local health jurisdictions to implement HIV Names reporting as required by state statute. The Subcommittee had approved this funding in its April 16th hearing. These funds are to be used as an offset from the January budget and count towards the federal MOE requirements.

o *$7.3 million Recognized as General Fund Savings.* No more than this amount can be claimed as overall General Fund savings or the state could potentially violate its federal MOE requirements and place $122 million in federal Ryan White CARE Act funds in jeopardy.

- **$10.5 million federal funds (Ryan White CARE Act Part B Funds) savings would be redirected on an *ongoing, permanent basis* as follows:**

o *$2.3 million Care Services Program.* This program provides funding to local agencies for medical and support services for persons living with HIV/AIDS. In 2006-07, the Office of AIDS allocated $11.8 million (federal funds) to this program. Funds are made available to all counties for the provision of primary medical care and a variety of supportive services that facilitate access to ADAP and primary medical care. Services include ambulatory

medical care, case management, oral health care, transportation, substance abuse treatment and other services. The $2.3 million would be an ongoing augmentation.

- o *$3.5 million for Case Management Program.* These funds would be used to augment 44 sites throughout the state. This program provides comprehensive cost effective, home and community-based services for persons living with HID/AIDS. The program maintains clients safely in their homes which avoids institutional care. It focuses on adults and children under the age of 13 years. In 2006-07, a total of $8.3 million ($6.4 million General Fund and $1.9 million federal funds) was allocated.
- o *$4.3 million for the Early Intervention Program.* The goals of this program are to prolong the health and productivity of HIV-infected persons and to interrupt the transmission of HIV. In 2006-07, a total of $7.1 million ($6.5 million General Fund and $600,000 federal funds) was allocated for the program.
- o *$430,000 for Capacity Building.* This is the same issue but an on-going amount of $430,000 in federal funds would be provided for the Office of AIDS to operate the AIDS Institute (as discussed under the $500,000 item, above).

Constituency Concerns. Constituency groups have raised no issues regarding the funding level proposed for the ADAP or the various redirections of funding to other HIV/AIDS programs which are augmentations. However, some constituency groups would like to spend a portion of the $7.3 million identified in the Administration's proposal as overall General Fund savings. Specifically, some groups are seeking an increase of $2.5 million for HIV testing using mobile clinics in hard to reach communities.

Legislative Analyst's Office (LAO) Recommendation. The LAO raises no issues regarding the funding levels proposed by the Administration in their May Revision, except they believe that $2.8 million of the $7.3 million in one-time General Fund savings should be identified as ongoing savings.

Subcommittee Staff Recommendation. **First**, the Office of AIDS should be commended on their continued efficient and client responsive operations of the ADAP. This program continues to be a national model. **Second,** it is recommended to not make any fiscal changes to the Administration's proposal. The programs identified for increases have merit and the Office of AIDS tried to cover a wide spectrum of important service areas. **Third** it is recommended to modify the Administration's proposed Budget Bill Language regarding the six "Eligible Metropolitan" areas as follows (Item 4265-111-001):

> "2. Of the funds appropriated in this item, the Office of AIDS ~~may~~ **shall** redirect up to $1.8 million from the AIDS Drug Assistance Program to support the transition of HIV/AIDS care and treatment service delivery systems in up to six federally designated Eligible Metropolitan Areas (EMAs) if federal funding for an EMA declines. The funding made available through this redirection to any EMA shall not exceed the EMA's funding shortfall relative to its 2006 grant award."

Questions. The Subcommittee has requested the Department of Public Health, Office of AIDS, to respond to the following questions.

1. Office of AIDS, Please provide a *brief* description of the May Revision proposal.

2. Follow-Up to Licensing and Certification Fees Discussion

Prior Subcommittee Hearings and Action Taken. The Subcommittee has discussed the Governor's proposed significant increases to Licensing and Certification Fees for health care facilities in two prior hearings (April16th and May 7th). Through these hearings the following actions were taken:

- Approved additional staff for the Licensing and Certification (L&C) Division to expand regulatory and oversight functions as contained in chaptered legislation;
- Directed that $7 million (L&C Funds) from unsent current-year funds be used on a *one-time only basis* to offset L&C Fee increases in the budget year. Specifically, this one-time only adjustment is to be applied in the same manner as was the General Fund subsidy provided by the Legislature through the Budget Act of 2006.
- Adopted a technical adjustment to reduce by $400,000 (L & C Fees) on a *one-time only basis* the budget year appropriation to reflect natural salary savings that will occur as part of the phased-in hiring process. This action will reduce L&C Fees in the budget year.
- Directed the Administration to re-calculate the L&C Fees by individual clinic facility types, versus the "bundled" approach they had used, to more appropriately reflect the L&C Fee amounts and services provided to various clinics.
- Adopted *placeholder trailer bill language* to capture certain revenues obtained by the L&C Division to fund expenditures of the program but are not recognized (i.e., off-set) in the L&C Fee amounts. These revenues include: **(1)** new, initial surveys; **(2)** changes of ownerships—"CHOWs"; and **(3)** late payment fees made by facilities that did not pay their L&C Fees on time.
- Adopted Budget Bill Language to have the Office of State Audits and Evaluations (OSAE) to review, document, and where appropriate evaluate, the various aspects of the methodologies used by the L&C Division in the development and calculation of fees for the payment of services provided by the L&C Division.

Issues. The Governor's May Revision does *not* propose any changes to the original January fee schedule. However, it should be noted that the L&C Division has provided considerable technical assistance to Subcommittee staff and constituency groups in an effort to provide transparency on how the fees were developed and to assist in crafting potential options for making changes to the proposed fees.

The Subcommittee requested constituency groups to provide written comment for consideration at the May Revision on additional options for changes, besides those actions already taken by the Subcommittee on May 7th. ***Key* aspects of these constituency requests are referenced below:**

- *District Hospitals with Less than 100 Beds.* The Budget Act of 2006 provided General Fund support to fully fund the licensing and certification expenditures for these small, usually rural, hospitals (27 hospitals). The Subcommittee is in receipt of a letter requesting the same support as provided last year. **Subcommittee staff notes that it would cost $364,333 (General Fund) to fund this action** (at $306.42 per bed fee level).

- *Adult Day Health Care Facilities (ADHC).* The Subcommittee is in receipt of a letter requesting statutory changes to have ADHC facilities, which presently have an L&C Fee structure based on a "per facility" basis (i.e., a flat fee). The Association would like to change this structure to have their L&C Fees calculated based on "licensed capacity" since ADHC facilities range from a low of 30 to a high of 300 for licensed capacity. As such, the Association is requesting statutory language as follows:

  > "The Department shall be granted the authority to re-classify Adult Day Health Care facilities from a per facility fee category to a per unit fee category based on licensed capacity."

  In discussions with the L&C Division, they contend that though this proposed approach *may* have merit, further analysis and discussion needs to be had to discern what the full implications are of this potential change from a fiscal perspective, as well as to identify a reliable data source regarding licensed capacity. In addition, the L&C Division notes that other categories of health care facilities may prefer this licensure capacity approach, versus the per facility approach, for determining L&C Fees. As such, the L&C Division would prefer not to take action through the budget process solely for ADHC facilities but to discuss these issues after the Office of State Audits and Evaluations (OSAE) has completed its analysis, and through the policy committee process which provides for a longer discussion period.

  Subcommittee staff would concur with the L&C Division on this issue in that additional work needs to be done to better understand the implications of this change. **Due to the timing of the budget process, it is suggested to not take action on this issue without prejudice.**

- *Nursing Homes.* The Subcommittee is in receipt of a letter noting several key issues. **First,** the Association questions the productivity level assigned for the L&C surveyors (1,364 hours is assumed versus a standard 1,800 hours per year which is normally assumed for other state staff positions). Subcommittee staff notes that this is an issue which was discussed last year through the budget process. The L&C Division which was woefully understaffed needed to bring in a substantial number of new L&C surveyors which require considerable training for surveyor work and transition time to working in the field going to the various facilities. It is assumed that this productivity level will be reviewed by the OSAE when they conduct their review and that the L&C Division may reconsider this assumption based on having more experienced staff next year. **Subcommittee staff recommends no budget action on this issue since Budget Bill Language has already been adopted regarding the OSAE review.**

  Second, the Association notes that the L&C Fees are not presently prorated when a facility changes ownership. As a result, fees are paid by both the new and old owners of a single facility during the years in which the ownership change transaction occurs. Therefore, the Association would like to have the L&C Division pro-rate the fee. However, the L&C Division states that this is not workable since they normally would have to conduct two L&C surveys due to the change in ownership. **Subcommittee staff recommends no budget action on this issue.**

Third, the Association is seeking a methodology for Intermediate Care for Developmentally Disabled (ICF-DD) and related facilities (ICF-DD/N and ICF-DD-H), which would enable them to capture the L&C Fees that they pay within their Medi-Cal reimbursement rate. Subcommittee staff believes this is valid issue but it needs to be vetted with the Medi-Cal Program. Any changes to Medi-Cal rates must be approved by the federal CMS. The existing Medi-Cal rate reimbursement provides the DHS with certain flexibilities for changes and Subcommittee staff believes this requested change can be worked out administratively with no budget year implications, with minor out-year budget costs. **No Subcommittee action is recommended for this purpose.**

Lastly, the Association offers several suggestions to improve the L&C Division's annual licensing report (as required by statute) by providing additional data. Generally, these data suggestions include the following: (1) provide information on the standard average hours or descriptions of the types of federal certification and state licensing workload activities; (2) provide L&C surveyor workload hours utilized as a standard to calculate the budgeted positions; and (3) describe the overhead utilized within the L&C Division that is non-surveyor related. **Subcommittee staff believes that these are good suggestions and that the L&C Division should see how they can provide this information in next year's report. No Subcommittee action is needed for this purpose.**

- *Primary Care Clinics.* The Subcommittee is in receipt of a letter requesting two items. **First,** the clinics would like to change their L&C survey schedule from once every three years to once every five or even potentially eight years. The L&C Division believes there may be merit to making a change to the schedule, which would require a statutory change, but only after the L&C Division "catches-up" on their review of the primary care clinics. Subcommittee staff believes any decision regarding the frequency of a health care facilities survey schedule should be had via the policy committee process. **No budget action is recommended for this purpose.**

  Second, primary care clinics that have JCAHO (an independent accreditation entity) certification do not need to have L&C Division perform periodic re-surveys. However, presently the L&C Division does *not* have an accessible and reliable way to know when primary care clinics have JCAHO certification. As such, the L&C Division includes all primary care clinics in their L&C Fee projections. Therefore, the Association is requesting a change to this process. **Subcommittee staff recommends adopting placeholder trailer bill language, with final language to be worked out with the Administration, to address this concern. The placeholder trailer bill language is as follows:**

  > "Primary care clinics may submit verification of JCAHO certification to the Licensing and Certification Division within the Department of Public Health for entry into the Electronic Licensing Management System for purposes of data collection and extraction for licensing and certification fee calculations."

- *Home Health Agencies.* The Subcommittee is in receipt of a letter requesting several items. Among other things, the Association is seeking to change the structure of their rate to distinguish the difference between a "parent" and a "branch" as an appropriate fee category. Under their proposal, a "parent" would pay a larger fee and the "branch" would pay $1,500, and "new applicants" would pay an additional $1,500 in addition to their "parent" fee. In essence, the Home Health Agencies want to establish fees that they believe are proportionate to the workload associated oversight of these facilities. It is a tiered approach to fees.

  The L&C Division states they are willing to work with the Association regarding a longer-term approach to the tiered fees. However at this time more work needs to be done regarding what exact tiered really reflects the L&C workload and what the fee amounts for this would be applicable. Policy legislation would be more applicable at this point in time.

Background—Summary of Governor's Proposed Licensing and Certification Fee Increases. The table below displays the Governor's fee increases for 2007-08 as compared to the Budget Act of 2006. As previously discussed in the April 16th hearing and the May 7th hearing, the Administration's proposal to eliminate $7.2 million in General Fund support is contrary to the agreement crafted with the Legislature through the Budget Act of 2006, and added to the fee increases as noted below.

Administration's Proposed Fee Schedule for 2007-08 Compared to Budget Act of 2006 Fees

Facility Type	Fee Category	2006-07 Fee (Budget Act 2006)	Administration's 2007-08 Fee	Difference (+/-)
Referral Agencies	per facility	$5,537.71	$6,798.11	$1,260.40
Adult Day Health Centers	per facility	4,650.02	4,390.30	-259.72
Home Health Agencies	per facility	2,700.00	5,568.93	2,868.93
Community-Based Clinics	per facility	600.00	3,524.27	2,924.27
Psychology Clinic	per facility	600.00	3,524.27	2,924.27
Rehabilitation Clinic (for profit)	per facility	2,974.43	3,524.27	549.84
Rehabilitation Clinic (non-profit)	per facility	500.00	3,524.27	3,024.27
Surgical Clinic	per facility	1,500.00	3,524.27	2,024.27
Chronic Dialysis Clinic	per facility	1,500.00	3,524.27	2,024.27
Pediatric Day Health/Respite	per bed	142.43	139.04	-3.39
Alternative Birthing Centers	per facility	2,437.86	1,713.00	-724.86
Hospice	per facility	1,000.00	2,517.39	1,517.39
Acute Care Hospitals	per bed	134.10	309.68	175.58
Acute Psychiatric Hospitals	per bed	134.10	309.68	175.58
Special Hospitals	per bed	134.10	309.68	175.58
Chemical Dependency Recovery	per bed	123.52	200.62	77.1
Congregate Living Facility	per bed	202.96	254.25	51.29
Skilled Nursing	per bed	202.96	254.25	51.29
Intermediate Care Facility (ICF)	per bed	202.96	254.25	51.29
ICF-Developmentally Disabled	per bed	592.29	701.99	109.70
ICF—DD Habilitative, DD Nursing		1,000 per facility	701.99 per bed	3,211.94 per facility
Correctional Treatment Centers	per bed	590.39	807.85	217.46

Subcommittee Staff Recommendation. In *addition* to the actions taken in the May 7th hearing, the following actions are recommended: **(1)** increase by $364,333 (General Fund) to pay the L&C Fees for District Hospitals with less than 100 beds; **(2)** increase by $2.6 million (General Fund) to reduce the L&C Fees of certain health care facilities using the same methodology as done in the Budget Act of 2006; **(3)** adopt statutory language regarding other L&C revenues which had been previously adopted as "placeholder" language in the May 7th hearing; **(4)** adopt statutory language regarding the use of the General Fund support; and **(5)** adopt placeholder trailer bill language regarding the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification as referenced above.

The trailer bill language for recommendation 3, above, is as follows:

> Amend Section 1266 (d)(1) of Health and Safety Code by *adding* the following paragraph:
>
> (E) Amounts actually received for new licensure applications (including change of ownership applications) and late payment penalties (pursuant to Section 1266.5) during each fiscal year shall be calculated and ninety-five percent (95%) shall be applied to the appropriate fee categories in determining Licensing and Certification Program fees for the second fiscal year following receipt of those funds. The remaining five percent (5%) shall be retained in the fund as a reserve until appropriated.

The trailer bill language regarding recommendation 4, above, is as follows:

> Amend Section 1266 (a) of Health and Safety Code as follows:
>
> ~~(a) Unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation, the Licensing and Certification Division shall, no later than the beginning of the 2009-10 fiscal year, be supported entirely by federal funds and special funds.~~
>
> (a) The Licensing and Certification Division shall be supported entirely by federal funds and special funds by no *earlier* than the beginning of the 2009-10 fiscal year unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation. For the 2007-08 fiscal year, General Fund support shall be provided to offset licensing and certification fees in an amount of not *l*ess than $3 million.

The General Fund support is provided to selected health care facilities which have historically not required as much oversight by the L&C Division, and are smaller not-for-profit providers who serve a large volume of Medi-Cal patients.

The proposed L&C Fees based on the Subcommittee's actions would be as shown in the table below. It should be noted that the final L&C Fees to be paid would be those to be published by the Department of Public Health within 14 days of enactment of the annual Budget Act (as contained in Section 1266 of the Health and Safety Code).

Subcommittee Revised L&C Fee Structure Based on Actions (of May 7th & Today)

Facility Type	Fee Category	Administration's 2007-08 Fee	Senate Subcommittee #3	Difference (+/-)
Referral Agencies	per facility	$6,798.11	$6,798.11	--
Adult Day Health Centers	per facility	4,390.30	$4,390.30	--
Home Health Agencies	per facility	5,568.93	$3,876.23	-$1,692.70
Community-Based Clinics	per facility	3,524.27	$876.08	-$2,648.19
Psychology Clinic	per facility	3,524.27	$2,303.86	-$1,220.41
Rehabilitation Clinic (for profit)	per facility	3,524.27	$402.85	-$3,121.42
Rehabilitation Clinic (non-profit)	per facility	3,524.27	$402.85	-$3,121.42
Surgical Clinic	per facility	3,524.27	$2,848.92	-$675.35
Chronic Dialysis Clinic	per facility	3,524.27	$3,246.45	-$277.82
Pediatric Day Health/Respite	per bed	139.04	$138.51	-$0.53
Alternative Birthing Centers	per facility	1,713.00	$1,713.00	--
Hospice	per facility	2,517.39	$727.96	-$1,789.44
Acute Care Hospitals	per bed	309.68	$306.42	-$3.27
Acute Psychiatric Hospitals	per bed	309.68	$306.42	-$3.27
Special Hospitals	per bed	309.68	$306.42	-$3.27
Chemical Dependency Recovery	per bed	200.62	$200.62	--
Congregate Living Facility	per bed	254.25	$253.57	-$0.68
Skilled Nursing	per bed	254.25	$253.57	-$0.68
Intermediate Care Facility (ICF)	per bed	254.25	$253.57	-$0.68
ICF-Developmentally Disabled	per bed	701.99	$473.26	-$228.73
ICF—DD Habilitative, DD Nursing		701.99 per bed	$473.26	-$288.73
Correctional Treatment Centers	per bed	807.85	$807.85	--

Questions. The Subcommittee has requested **both** the public and the L&C Division to provide *brief* comment regarding each of these issues and the recommendations.

3. Implementation of Proposition 84 Bond Act of 2006 on Safe Drinking Water

Prior Subcommittee Hearing. In the April 30th Subcommittee hearing, the Department of Public Health's (DPH) portion of the Proposition 84 Bond was discussed. Two issues were raised in the discussions. **First**, questions were raised by the Subcommittee regarding how the DPH is reaching disadvantaged and severely disadvantaged communities regarding safe drinking water projects. **Second**, clarification regarding the use of a contractor for making determinations regarding what constitutes a disadvantaged and severely disadvantaged community was requested. **No issues were raised regarding the need for DPH resources to implement Proposition 84 or regarding the appropriation of funds as contained in the Finance Letter.**

First, the DPH has provided the Subcommittee with the following response regarding the development of criteria to implement provisions contained in Proposition 84 regarding disadvantaged and severely disadvantaged communities. Key actions have been, or will be, as follows:

- DPH intends to contract with non-profit organizations such as Self Help Enterprises to assist disadvantaged and severely disadvantaged water systems. These organizations have the trust of the community, are multilingual and have technical abilities to assist the community in applying and receiving Proposition 84 drinking water grants.
- In the development of the Proposition 84 grant criteria, regular meetings were held with stakeholders such as the Environmental Justice Coalition for Water and Clean Water Action to obtain their input and comments. The stakeholders participated in the criteria development process from its inception to the development of the final criteria.
- Public meetings were also conducted to receive comments on the criteria in Chino, Visalia and Sacramento. Attendees at the meetings included small water systems, consultants and environmental organizations.
- A "universal" pre-application will be available by June 2007 which will allow public water systems to apply once for funding for all DPH programs (Proposition 84, Proposition 50 and the Drinking Water State Revolving Fund). This will make it easier for disadvantaged and severely disadvantaged communities to apply.
- Disadvantaged and severely disadvantaged projects for the first year of Proposition 84 grant funding will be selected from the Drinking Water State Revolving Fund. This will ensure that grant funds are made available to those most in need in 2007-08. Any disadvantaged and severely disadvantaged water system projects on the Drinking Water State Revolving Fund health-based project priority list that are not selected in the first round, will not have to complete a pre-application. The DPH will place these projects on the Proposition 84 project priority list with its appropriate ranking.
- The DPH has prepared maps of the San Joaquin Valley and identified 80 to 90 small community water systems with less than 200 service connections that the DPH believes are disadvantaged and severely disadvantaged communities. Other areas of the state are being mapped to identify these water systems.

- DPH criteria give priority to consolidation of disadvantaged and severely disadvantaged water systems. Encouraging consolidation and regional facilities among these water systems results in lower water rates and assists the community in obtaining funding to operate and maintain the treatment facilities.

Second, the DPH has provided the following response regarding their proposal to send $50,000 to enter into a financial services contract to determine median household income for disadvantaged and severely disadvantaged communities. The DPH notes that they had been contracting for these types of services for the other public water programs since 1998 (via the Department of Water Resources).

The DPH needs this information to determine the disadvantaged status of community water systems. The financial services provider can make the finer determinations of household income of smaller units within census tracks. **Without this capability by the financial services provider, a small water system may be found not to be disadvantaged when it really is.** To make the financial status determination, databases must be available that supplies the user with updated household characteristics such as income, household size, census tract and age of householder, new households in area, and consumer financial information from consumer marketing databases.

The DPH's objective of using financial contract services is to ensure that data on disadvantaged and severely disadvantaged communities with water systems is consistent, reliable, and defensible and provided in a reasonable amount of time to avoid delaying grant funding to applicant small water systems.

Background on the Finance Letter Request. The Department of Public Health (DPH) is requesting two budget adjustments to begin implementation of Proposition 84—the Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Projection Bond Act of 2006.

First, the DPH is requesting an appropriation of $2 million (Proposition 84 Bond Funds) to fund:

- 16.5 staff (primarily engineers, scientists and support staff) at the DPH;
- Contract for $200,000 for technical assistance outreach to disadvantaged and severely disadvantaged communities;
- Contract for $50,000 to analyze and annually update household income data in selected areas which is used to determine "disadvantaged" and "severely disadvantaged" communities as referenced in the proposition;
- Implement an interagency agreement for $50,000 with the Department of General Services (DGS) to conduct certain CA Environmental Quality Act (CEQA) activities. The DPH states that there are several projects each year that will require specialized CEQA knowledge outside the capabilities of their in-house staff. These include instances where there is a need for biological habitat suitability studies, archeological reports, cultural resources surveys and biological field surveys. (This is also done under Proposition 50.)

Second, the DPH is requesting local assistance expenditure authority of $47.3 million (Proposition 84 Bond Funds) for the budget year. In addition, the Administration is proposing Budget Bill Language to enable the $47.3 million to be available for expenditure through 2010. This longer expenditure period provides for flexibility in working with the small community water systems and recognizes the timeframes that some of the projects may require due to the engineering work and construction work often involved in the projects.

The $47.3 million consists of the following components:

- $9.1 million (Proposition 84 Bond Funds) for Emergency Grants. This would appropriate the entire amount available for this purpose.
- $27.2 million (Proposition 84 Bond Funds) for small community water drinking systems. The DPH assumes that this amount will be expended annually, over the course of six-years, for total expenditures of $163 million.
- $9.1 million (Proposition 84 Bond Funds) for prevention and mitigation of ground water contamination. The DPH assumes that this amount will be expended annually, over the course of six-years, for total expenditures of $54.3 million.

Background—Proposition 84, Safe Drinking Water & Water Quality Projects. This act contains several provisions that pertain to the Department of Public Health (DPH). It should be noted that 3.5 percent (annually) of the bond funds are to be used to service the bond costs, and up to 5 percent (annually) can be used for DPH state support expenditures. The remaining amounts are to be used for local assistance. A summary of the provisions for which the local assistance funds can be used is as follows:

- $10 million for Emergency Grants. Section 75021 of the proposition provides funds for grants and direct expenditures to fund emergency and urgent actions to ensure that safe drinking water supplies are available. Eligible project criteria includes, but is not limited to: (1) providing alternate water supplies including bottled water where necessary; (2) improvements to existing water systems necessary to prevent contamination or provide other sources of safe drinking water; (3) establishing connections to an adjacent water system; and (4) design, purchase, installation and initial operation costs for water treatment equipment and systems. Grants and expenditures *shall not exceed $250,000* per project.

- $180 million for Small Community Drinking Water. Under Section 75022 of the proposition, grants for small community drinking water system infrastructure improvements and related actions to meet safe drinking water standards will be available. Statutory authority requires that priority be given to projects that address chemical and nitrate contaminants, other health hazards, and by whether the community is disadvantaged or severely disadvantaged.

  Eligible recipients include public agencies, schools, and incorporated mutual water companies that serve disadvantaged communities. Grants may be made for the purpose of financing feasibility studies and to meet the eligibility requirements for a construction grant.

Construction grants are limited to $5 million per project and not more that 25 percent of the grant can be awarded in advance of actual expenditures. Up to $5 million of funds from this section can be made available for technical assistance to eligibility communities.

- $50 million for Safe Drinking Water State Revolving Fund Program. As discussed under Agenda issue #1—Proposition 50 implementation, the Safe Drinking Water State Revolving Fund Program enables California to provide a 20 percent state match to draw down federal capitalization funds. Once the Proposition 50 bond funds are exhausted for this purpose, the Proposition 84 bond funds will be used. This conforms to Section 75023 of the proposition.

- $60 million Regarding Ground Water. Section 75025 provides for grants and loans to prevent or reduce contamination of groundwater that serves as a source of drinking water. Statutory language requires the DPH to require repayment for costs that are subsequently recovered from parties responsible for the contamination. Language in the proposition also provides that the Legislature may enact additional legislation on this provision as necessary.

Subcommittee Staff Recommendation—Approve Finance Letter. Subcommittee staff believes the DPH has appropriately responded to the questions poised by the Subcommittee in its April 30th hearing. It is therefore recommended to approve the Finance Letter as requested.

Questions. The Subcommittee has requested the Department of Public Health to respond to any questions from Subcommittee Members if needed.

B. Item 4280 Managed Risk Medical Insurance Board *(Discussion Items)*

1. Healthy Families Program—Baseline and Caseload Estimate (Issue 106)

Governor's May Revision. A total of $1.114 billion ($400.4 million General Fund, $703.9 million Federal Title XXI Funds, $2.2 million Proposition 99 Funds, and $7.6 million in reimbursements) is proposed for the Healthy Families Program (HFP).

The May Revision reflects an overall *increase* of $23.8 million ($8.2 million General Fund) as compared to the January budget.

The proposed adjustments mainly reflect (1) an average increase of 3.1 percent in the rates paid to participating health plans, dental plans and vision plans (for children aged 1 to 19 years); **(2)** an average increase of 3.2 percent in the rates paid to plans serving infants (aged 0 to 1 year); **(3)** an increase in caseload of 3,918 children, as noted below; and **(4)** updated data for the Certified Application Assistance Incentive payments.

The rate increase for plans serving children aged 1 to 19 years means that on average participating plans will receive $98.88 per member per month. For those plans serving infants, they will receive on average $237.14 per member per month. The Managed Risk Medical Insurance Board (MRMIB) negotiates rates with the plans.

The May Revision assumes a total enrollment of 919,516 children as of June 30, 2008, an increase of 3,918 children as compared to the January budget. The May Revision caseload reflects an increase of about 7.7 percent over the revised current-year.

Total HFP enrollment of **919,516 children** is summarized by population segment below:

- Children in families up to 200 percent of poverty 612,827 children
- Children in families between 201 to 250 percent of poverty 197,135 children
- Children in families who are legal immigrants 15,806 children
- Access for Infants and Mothers (AIM)-Linked Infants 15,937 children
- New children due to changes in Certified Application Assistance 8,458 children
- New children due to various modifications in the enrollment process 58,749 children
- New children due to implementation of SB 437, Statutes of 2006 10,604 children

Overall Background—Description of the Healthy Families Program. The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to state employees.

Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

Summary of Eligibility for the Healthy Families Program (HFP) ***(See Chart in Hand Out)***

Type of Enrollee in the HFP	Income Level Based on Federal Poverty	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers (AIM).	200 % to 300 %	If income from 200% 2o 250%, covered through age 18. If income is above 250 %, they are covered up to age 2.
Children ages one through 5 years	133 % to 250 %	Healthy Families Program covers above 133 percent because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100 % to 250 %	Healthy Families Program covers children in families above 100 %. Families with two children may be "split" between programs due to age.
Some children enrolled in County "Healthy Kids" programs. These include (1) children without residency documentation; and (2) children from 250 percent to 300 percent of poverty.	Not eligible for Healthy Families Program, including 250 percent to 300 percent	State provides federal S-CHIP funds to county projects as approved by the *MRMIB.* Counties provide the match for the federal funds.

Subcommittee Staff Recommendation—Approve. The May Revision estimate for the Healthy Families Program reflects reasonable caseload and fiscal adjustments. No issues have been raised regarding the baseline program.

Individual issues regarding policy changes that are reflected in the May Revision are discussed below in the Agenda.

Questions. The Subcommittee has requested the Managed Risk Medical Insurance Board (MRMIB) to respond to the following questions.

1. **MRMIB**, Please provide a brief overview of the key components of the May Revision, regarding this baseline estimate.

2. Change in the Healthy Families to Medi-Cal Bridge—Fiscal & Trailer (Issue 109)

Governor's May Revision. The Administration is proposing trailer bill language and a *net* decrease of $3.8 million (decrease of $1.3 million General Fund) in the Healthy Families Program, with corresponding adjustments in the Medi-Cal Program (reflected in the Medi-Cal estimate adjustment as noted below).

Specifically, the Administration needs to implement a "presumptive eligibility" process to replace the existing Healthy Families Program to Medi-Cal Program "bridge" for children. This "bridge" is needed in order to ensure that children maintain access to health care while they are being processed for eligibility into the Medi-Cal Program. The "presumptive eligibility" process will provide up to 60-days of Medi-Cal eligibility coverage. This provides for a reasonable time frame for the child to be enrolled into the Medi-Cal Program.

California's existing Waiver to operate a Healthy Families Program to Medi-Cal Program "bridge" expired as of January 1, 2007. Though the Administration tried to negotiate with the federal CMS to extend this Waiver, the federal CMS imposed conditions on the state that were not acceptable. Specifically, the federal CMS was going to require a retroactive payment for California to make regarding the difference in federal funding levels (i.e., the 65 percent federal S-CHIP match versus the 50 percent federal Medicaid match).

Therefore due to the federal CMS limits, the Administration is proposing state statutory change to use a different mechanism to "bridge" between programs. A "presumptive eligibility" process will now be used for those children who were enrolled in the Healthy Families Program but whose family income level has decrease so that the child is now likely eligible for Medi-Cal Program services.

Conceptually, once a child no longer receives Healthy Families coverage (i.e., discontinued), presumption eligibility through the Medi-Cal Program will be provided by submitting a Medi-Cal application for the child through the "Single Point of Entry" (i.e., where joint program applications are processing by the HFP Administrative vendor). Medi-Cal accelerated enrollment will then be established for the child (meaning the child can receive timely health care services through the Medi-Cal Fee-for-Service system).

It should be noted that the Medi-Cal Program already has federal CMS authority to operate presumptive eligibility mechanisms, as well as to do accelerated enrollment. This is all contained in the State's Medicaid Plan.

There are several reasons why a child is discontinued from enrollment in the Healthy Families Program. Among other things, is that the family's income has dropped making their child eligible for the Medi-Cal Program and not Healthy Families. (Federal law prohibits the expenditure of federal S-CHIP funds for Medicaid eligible children.)

Due to the proposed change, the state will no longer be receiving the federal S-Chip 65 percent match for the "bridge" but instead, will be receiving the federal Medicaid 50 percent match for the "presumptive eligibility". Therefore, the Medi-Cal Program reflects increased

General Fund support.

Subcommittee Staff Recommendation—Approve Funding and Trailer Bill. It is unfortunate that the federal CMS is unwilling to continue California's Healthy Families to Medi-Cal bridge program. However, the state can use the presumptive eligibility process in order to ensure that children continue to have access to health care coverage for 60 days to enable their eligibility for the Medi-Cal Program to be determined.

Questions. The Subcommittee is requesting the MRMIB and DHCS to respond to the following questions:

1. **MRMIB and DHCS**, Please provide a brief summary of the May Revision proposal and how it will operate.

3. Access for Infants and Mothers (AIM) Program (Issues 107 & 111)

Governor's May Revision. A total of $133.2 million ($8.3 million General Fund, $51.6 million Perinatal Insurance Fund and $73.3 million federal funds) is proposed for the Access for Infants and Mothers (AIM) in 2007-08.

This funding level reflects an overall *net* decrease of $5.5 million in total funds but an increase of $8.3 million in General Fund support as compared to the January budget. The *net* decrease of 4 percent in total funds is largely due to federal fund changes resulting from corrections to the way subscriber contributions are budgeted.

Based on the revised revenue projection for Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds, established in 1988), there is insufficient state funding for AIM. Proposition 99 Funds are deposited into the Perinatal Insurance Fund for expenditure for AIM and are used to draw down the federal match. **Therefore, the Administration is proposing to use $8.3 million in General Fund support in lieu of Proposition 99 Funds.**

Background—Access for Infants and Mothers (AIM). The Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage.

As of July 1, 2004, infants born to AIM women are automatically enrolled in the Healthy Families Program (HFP) at birth. Infants born during 2004-05 to AIM mothers who enrolled in AIM prior to July 1, 2005 will remain in AIM through two years of age. Therefore, infant enrollment is declining and shifting to the HFP. This is because infants will age out of the AIM Program at two years old while no new infants will be enrolled after July 1, 2004, unless the AIM mother was enrolled prior to that date. Therefore, the AIM Program is transitioning to focusing only on pregnant women and 60-day post partum health care coverage.

Background—Major Risk Medical Insurance Program. The Major Risk Medical Insurance Program began serving subscribers in 1991. It provides comprehensive health insurance benefits to individuals who are unable to purchase private coverage because they were denied individual coverage or were offered it at rates they could not afford. Subscribers are charged a monthly premium ranging from 125 percent to 137.5 percent of their plan's standard average individual rate adjusted for the Major Risk Medical Insurance Program benefit standards. The premiums are subsidized through Proposition 99 Funds (Cigarette and Tobacco Surtax Fund). Because the appropriation from Proposition 99 Funds is limited to $40 million annually.

There are about 7,800 individuals presently enrolled in the Major Risk Medical Insurance Program.

Legislative Analyst's Office Comment. The LAO questions whether Proposition 99 Funds used for the Major Risk Medical Insurance Program could be redirected to fund the AIM Program and thereby, not utilize any General Fund support for AIM, or at least some level less than the May Revision proposal of $8.3 million (General Fund).

The LAO states that enrollment for the Major Risk Medical Insurance Program has been below the enrollment cap for the past few months. The LAO has not been able to compare current-year projected expenditures with actual expenditures because the MRMIB has been unable to provide updated fund condition information for the Major Risk Medical Insurance Program because payment requests from participating plans have not yet been received.

The LAO believes that any unspent Major Risk Medical Insurance Program balance could be used on a *one-time only* basis to fund the Major Risk Medical Insurance Program in lieu of its proposed allocation of Proposition 99 Funds.

This action in turn, would free up Proposition 99 revenues to be placed into the Perinatal Insurance Fund to be used for the AIM Program. Consequently, less General Fund support would be needed for the AIM.

Administration's Response to LAO Comments. The Managed Risk Medical Insurance Board (Board) states that they need two pieces of information that are critical to inform the decision making process as to whether unspent funds are available to be used as the LAO is contemplating.

These two pieces of information are: **(1)** claims payment information from all participating plans; and **(2)** an analysis of the Major Risk Medical Insurance Program's benefit plan design being conducted which will not be available until June.

The Board notes that the largest participating health plan in the Major Risk Medical Insurance Program is Blue Cross of California and they have not yet submitted their 2006 claims. The Board is aggressively pursing claim information but will probably not have it for a while.

Subcommittee Staff Recommendation—Approve May Revision. Though the LAO raises a good point, it is unknown at this point in time if funds are available within the MRMIP to redirect. As such, it is recommended to adopt the May Revision.

Questions. The Subcommittee has requested the MRMIB to respond to the following questions.

1. **MRMIB**, Please provide a *brief* summary of the May Revision request.
2. **MRMIB**, Please comment on the concerns raised by the LAO.

C. Item 4260 Department of Health Care Services *(Discussion Items)*

1. California Children's Services (CCS) Program: Significant Concerns with Access to Necessary Durable Medical Equipment (DME) & Medical Supplies

Issue. Constituency groups, including Children's Hospitals, medical supply companies, durable medical equipment providers, children specialty care groups and others, have expressed considerable concerns with limited access to medically necessary equipment and supplies under the California Children's Services (CCS) Program. This has been an ongoing issue for at least the past year, if not longer, and has **reached a crisis point** in many areas through out the state.

Though the Department of Health Care Services (DHCS) has had conversations with various groups regarding these concerns, including Subcommittee staff, nothing tangible and proactive has been done by the DHCS to remedy what is occurring out in the field.

Without appropriate durable medical equipment (DME) and supplies, children are delayed from being discharged from hospitals to their families. **These situations create havoc for the families, result in higher medical expenditures for everyone involved, including the state, and clearly do not represent the intended best medical practice standards for which the CA Children's Services Program is to be known.**

The Children's Regional Integrated Service System (CRISS), a coalition of nine counties and numerous children's specialty medical care groups, including hospitals, that provide CCS services in the greater Bay Area/Northern CA, conducted a recent survey (April 2007) of its members regarding access to these important medical items. **Key results of this survey are as follows:**

- Several hospitals, including some Children's Hospitals, needed to keep infants and children in the hospital from one day to as long as three months because of the inability to obtain equipment through the CCS Program.
- Several counties reported children being discharged on time but without equipment such as customized wheelchairs that took up to a month to obtain post-discharge due to delays in the CCS Program.
- CRISS reports that durable medical equipment (DME) and medical supply vendors are citing obstacles in both the authorization and payment processes as reasons to limit or eliminate their participation in the CCS Program and Medi-Cal. **For example, several larger companies that provide DME and medical supplies—such as Apria Healthcare and Shield—are either *not* taking CCS or Medi-Cal or are restricting the number of new clients for whom they will provide equipment or supplies.**
- Twelve babies have been kept in the hospital because of unavailability of apnea monitors.
- Four discharges were delayed in a two-week period due to the inability to secure pulse oximeters.
- Approximately one baby per month is being retained in the hospital because of problems

getting equipment necessary for discharge.

- One hospital reported delays with five pediatric patients waiting for ventilators, medical supplies, apnea monitors, home nursing and other services.
- Several hospitals reported paying for equipment and giving families' supplies in order to discharge children.
- Both hospitals and counties reported numerous complaints from parents and guardians who could not understand being denied access to services that are supposed to be covered by the CCS Program. Both also noted the following concerns as a result of delayed discharges:
    - ✓ Increased costs for extended hospitalizations;
    - ✓ Ethical concerns about disparity of care when privately insured patients have access to services and supplies; and
    - ✓ Multiple case management hours per patient spent on the phone attempting to coordinate care, obtain equipment, and follow-up on the lack of responses and changes in availability.

Various constituency groups have been trying to problem solve regarding these issues, and have offered tangible administrative suggestions and recommendations to the DHCS. Yet definitive action on the part of the DHCS has been lacking in the view of Subcommittee staff.

Background—California Children's Services (CCS) Program: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

The CCS is the oldest managed health care program in the state and the only *one focused specifically on children with special health care needs*. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as county funds.

Subcommittee Staff Recommendation. The CCS Program provides intensive, medical necessary services to infants, children and adolescents with significant specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence. CCS has specific standards of care and requires CCS-panel specialist to provide the care. If durable medical equipment and medical supplies cannot be accessed in a timely, medically professional manner, then the core program of services is at risk and

children and their families who rely on this program are *not* receiving the quality medical care that are suppose to be an integral part of the CCS Program.

In an effort to focus the DHCS' attention on this issue, the following Budget Bill Language is recommended (Item 4260-111-0001):

> "The Department of Health Care Services (DHCS) shall work with various constituency groups as appropriate to resolve issues with the timely discharge of patients enrolled in the California Children's Services (CCS) Program due to the lack of access to home care providers of durable medical equipment, medical supplies and home health services. The DHCS shall give consideration to utilizing the individual patient discharge plan initiated by a CCS paneled physician as an authorization for services for up to 90 days and to the timely approval for authorization of services to permit discharge of the CCS patient from the hospital setting within 48 hours."

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, What has been done to address these concerns specifically?
2. **DHCS**, How does the DHCS intend to proceed in the short-term and longer-term to address these issues?

2. Adjustments to AB 2911 (Nunez)--CA Drug Discount Prescription Drug Program

Prior Subcommittee Hearing. In the March 26th hearing, **the Subcommittee approved the budget proposal to implement the CA Drug Discount Prescription Drug Program as enacted by Assembly Bill 2911 (Nunez), Statutes of 2006.** Under the Administration's proposed implementation of this key legislation, the DHCS would conduct drug rebate negotiations, perform drug rebate collection and dispute resolution, and develop program policy, while a contractor would operate and manage the enrollment and claims processing functions.

Specifically, the January budget proposed the following adjustments:

- Increase of $8.8 million (General Fund) to support 16 positions within the Department of Health Care Services (DHCS) to conduct various implementation functions and to support a $6.8 million contract to design and implement the enrollment and claims processing functions. This General Fund increase is offset by a special fund appropriation as noted below

- Establishes a new item within the DHCS budget—Item 4260-006-001—which authorizes the State Controller to transfer up to $8.8 million (General Fund) to the DHCS to support the CA Drug Discount Prescription Drug Program (i.e., it transfers General Fund into the new special fund referenced below). Budget Bill Language provides authority to the Department of Finance (DOF) to increase the amount of this transfer after providing a 30-day notification to the Legislature.

- Establishes a new item within the DHCS budget—Item 4260-001-8040 (CA Drug Discount Prescription Drug Program Fund)—which is a special fund to be used to track and appropriate all payments received under the program, including manufacturer drug rebates. This item assumes an appropriation of $8.8 million which will be used to offset the General Fund expenditures for state support. The Administration is proposing trailer bill language to have this special fund be continuously appropriated and not subject to an annual appropriation through the Budget Act.

The budget also included $6.8 million for a contractor to design, develop and implement the client enrollment and claims reimbursement functions of the operations. The selected vendor will function as the Fiscal Intermediary for the program. This function will include, the entry of provider information into the claims processing system, the creation and maintenance of a computerized enrollment system for eligible Californians to enroll in the program and maintenance of a claims processing.

Governor's May Revision. The May Revision proposes to **(1)** technically reallocate contract support funds to local assistance to better reflect their budgeting methodology, and **(2)** reduce funding by $2.5 million for 2007-08 to reflect reduced expenditures for the Vendor contract. The DHCS states that they have selected a Vendor to serve as the Fiscal Intermediary for the program and the awarded costs are lower than originally anticipated.

Subcommittee Staff Recommendation—Approve with Technical Correction. It is recommended to approve the proposal but to make a technical correction by establishing a new item number—4260-119-8048 instead of using 4260-101-8040. This will keep the program separate and apart from the Medi-Cal local assistance item.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a brief summary of the May Revision change.

3. Medi-Cal Baseline Estimate Package & Technical Adjustments to Prior Actions

Governor's May Revision: The entire Medi-Cal Estimate is recalculated at the May Revision. As such, the Medi-Cal Estimate package needs to technically be adopted as a baseline **and *then*** individual issues are adjusted as needed (as discussed in the issues noted in the Agenda below).

The May Revision proposes Medi-Cal Program expenditures of $37.7 billion ($13.768 billion General Fund), excluding special funds provided to hospitals. This reflects a *net* increase of $330.3 million (**increase of $39.4 million General Fund**) as compared to the January budget. Estimated expenditures are shown below by category.

Summary Totals of Governor's May Revision for Medi-Cal Program

Component of the Medi-Cal Program	May Revision 2007-08
Medical Care Services	$34.743 billion ($13.765 billion General Fund)
County Administration	$2.685 billion ($800 million General Fund)
Fiscal Intermediary	$303.2 million ($102.7 million General Fund)
TOTAL	$37.732 billion ($14.668 billion General Fund)

The average monthly caseload is projected to be 6,603,000 Medi-Cal enrollees which represents a **decrease** of 98,000 people, or 1.5 percent from the January budget.

Among many various adjustments contained in the May Revision are the following:

- *Coverage for Former Agnews Developmental Center Residents.* An increase of $3.8 million ($1.9 million General Fund) is provided to recognize that some of the people moving from Agnews will enroll in Medi-Cal Managed Care plans (Santa Clara Family Health Plan, Alameda Alliance for Health and Health Plan of San Mateo). This adjustment is an estimate and will be updated in January 2008.
- *Dental Retroactive Rate Changes.* Decreases by $603 million ($301.5 million General Fund) to recognize a period from August 2004 through 2006 in which the Medi-Cal Program paid Delta Dental at a higher rate than what has subsequently been identified by independent actuaries regarding utilization and dental capitation rates implemented in 2005. The DHS states that these savings have been agreed to by Delta Dental.
- *Payments for Institutions for Mental Disease (Issue 214).* An increase of $24.1 million (General Fund) is provided in the current-year to fund a settlement with the federal

government regarding the claiming of non-federally eligible ancillary service costs. Federal funds are not available for ancillary services (such as physician services, pharmacy and laboratory) provided to Medi-Cal enrollee's ages 22 through 64 residing in Institutions for Mental Disease.

- *County Administration Adjustments*. An increase of $25.2 million ($12.6 million General Fund) for County Social Services Departments to implement the federal Deficit Reduction Act (DRA) that requires evidence of citizenship and identity as a condition of Medicaid eligibility for individuals who are applying for or currently receiving Medi-Cal benefits and who declare that they are citizens of the United States. Assembly Bill 1807, Statutes of 2006, specifies the requirements that counties have in this process, including assisting an individual in obtaining, presenting and supporting the acquisition of documentation required.

- *Medicare Payments (Issue 213).* A decrease of $20.5 million (General Fund) is proposed due to a reduction in the estimated growth of the average monthly eligibles. Under the Medicare Part D Program, states are required to contribute part of their savings for no longer providing a drug benefit to dual Medicare/Medi-Cal eligibles (i.e., the "clawback"). Declining growth in caseload affects this calculation relative to the January budget.

- *Hospital Financing Waiver.* A series of adjustments are contained in the May Revision to appropriately fund eligible safety net hospitals as contained in Senate Bill 1100 (Perata & Ducheny), Statutes of 2005.

- *Presumptive Eligibility for Healthy Families Enrollees.* An increase of $2.8 million ($1.4 million General Fund) is provided to replace the Healthy Families to Medi-Cal Bridge with a Medi-Cal presumptive eligibility process due to the expiration of Waiver that was done under the Healthy Families Program. (This issue is discussed under the Healthy Families Program).

- *Anti-Fraud Expansion for 2007-08.* Assumes savings of $42.5 million ($21.2 million General Fund) which are annualized savings recognized from additional staff that were added in the Budget Acts of 2000 and 2003 for audit compliance functions, laboratory reviews and various other activities.

- *Minor Consent Program.* In the May Revision the Administration exempts the Minor Consent Program from the requirements of the federal Deficit Reduction Act of 2005 (DRA) for expenditures of $18.9 million (General Fund), after accounting for a necessary technical adjustment. The $18.9 million (General Fund) increase is accounting for the fact that the DHCS will no longer claim federal funds for this program which provides services to pregnant minors. The Administration proposes to operate this program as a "state-only" program because application of the DRA requirements would serve as a barrier for minors to obtain medically needed services. (This does *not* include any surgical services for abortions.)

Prior Subcommittee Actions. The Subcommittee discussed the Medi-Cal Program in several hearings, and took three actions for adjustment to local assistance. These three adjustments were to correct technical items, including a reduction in County Administration costs for implementation of Senate Bill 437 regarding self-certification pilot projects, a fund

shift regarding some computer processing expenditures, and savings attributable to trailer bill language that had not been scored by the Administration as savings. **All of these savings adjustments have now been captured within the Governor's May Revision.**

Subcommittee Staff Recommendation—Approve with Technical Adjustment. The Administration has recognized an adjustment that needs to occur to their May Revision and has requested the Subcommittee to reduce by $1.150 million (General Fund) the amount provided to fund the minor consent program. This is purely a technical adjustment.

Therefore, it is recommended to (1) make the technical correction and (2) approve the remaining dollars for the Governor's May Revision for Medi-Cal local assistance needs.

The purpose of this action is to technically adopt the May Revision as a baseline and then individual issues will be adjusted as directed by the Subcommittee (as discussed in the issues noted in the Agenda below).

Questions. The Subcommittee has requested the DHCS to respond to the question below.

1. **DHCS**, Please provide a *brief* overview of the key components of the May Revision for the Medi-Cal Program.

4. Medi-Cal Program's Draft Response Re: Performance Measures and People with Disabilities and Chronic Conditions

Prior Subcommittee Hearing. In the May 7th hearing, the Subcommittee received a *draft* copy of the Department of Health Care Services (DHCS) response to the CA Healthcare Foundation's recommendations for performance standards for Medi-Cal Managed Care organizations serving people with disabilities and chronic conditions *at* the hearing.

The Legislature and various interested parties had been waiting for this report for at least a year.

Public testimony was provided by several constituency groups who articulated how the Medi-Cal Program overall—including the Fee-For-Service system and Managed Care system—needed to improve its overall programmatic structure when it comes to ensuring access, quality of care and performance measures for people who are aged, blind or disabled.

Issue. The draft DHCS report provides comment on the various recommendations made in the 92-page CA Healthcare Foundation Report but it does *not* offer any specific short-term or longer-term next steps and does *not* provide an **"action" plan** as to how the Administration can proceed.

The DHCS noted that timing of implementation of the various recommendations is related to the extent that resources are available. The May Revision did *not* include any additional resources for the DHCS in this area.

The DCHS states that several of the recommendations in which they agree recommend clarifications and changes to existing Medi-Cal Managed Care health plan contract language regarding consumer participation in health-plan decision making, providing support and advocacy for health plan members with disabilities and chronic health conditions, providing health plan member service guides in alternative formats, and several provisions related to care coordination and quality improvement. The DHCS *should be* proceeding on many of these aspects. However, at what pace will changes be made, and what will be the transparency of these actions?

The DHCS states that many of the other recommendations will require additional work and consultation with stakeholders before the DHCS can proceed. Again, it is unknown what this process will be at this time because the Administration has not provided or offered any public guidance on the topic.

Background—CA Healthcare Foundation Report (November, 2005). Under the support and direction of the California Healthcare Foundation, a comprehensive report prepared by several researchers was **released in November 2005** entitled: "Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions".

This **92 page report** was the outcome from various workgroup discussions convened during 2005 when discussions were at the forefront regarding improving Medi-Cal services to people

who happen to be in the aged, blind or disabled categories of the Medi-Cal Program (i.e., Fee-For-Service or Medi-Cal Managed Care). **Core objectives included the following recommendations for the Administration to pursue:**

- Develop performance standards and measures to foster improvements in quality of care for people with disabilities and chronic illness;
- Develop recommendations for how the DHS and other departments can support improvements in quality of care for this population;
- Develop recommendations for monitoring contract compliance; and
- Develop a tool to assess managed care plan readiness to serve people with disabilities.

The report recognized the need for considerable analysis and continued workgroup discussions around key topics, including: Accessibility; Provider Networks; Enrollment and Member Services; Benefit Management; Care Management; Coordination of Carved-Out and "Linked" Services; Quality Improvement; and Performance Measurement. ***Examples* of recommendations from the report included the following:**

- Conduct initial screen to identify immediate access and medical needs;
- Provide materials in alternative formats upon request;
- Provide assistance with navigating managed care;
- Expand cultural competency and diversity training requirements;
- Expand definition of "access";
- Determination of medical necessity should take into account maintenance of function;
- Broaden requirements to provide out-of-network services;
- Conduct quality improvement activities to address needs of people with disabilities and multiple chronic conditions;

Background—Information Regarding People with Disabilities Enrolled in Medi-Cal. In California there are **over 1 million people with disabilities enrolled in the Medi-Cal Program.** People who qualify for Medi-Cal based on disability (SSI determination) are very heterogeneous; there is no one category that can be labeled as "the disabled".

People with disabilities have a wide variety of physical impairments, mental health, and developmental conditions, and other chronic conditions. In addition, as noted by the California Healthcare Foundation, these individuals:

- Are increasing in numbers and account for a growing percentage of Medi-Cal expenditures;
- Have limited access to primary and preventive care services;
- Use a complex array of specialty, ancillary, and supportive services;
- Are much more likely to have multiple chronic or complex conditions;
- Require *personalized* durable medical equipment;

- Often need additional supports to access services (e.g., transportation, interpreters, and longer appointments); and
- Experience a dizzying array of physical, communication, and program barriers.

About 20 percent (over 280,000 people) of the Medi-Cal enrollees with disabilities are enrolled in the Medi-Cal Managed Care Program. The vast majority of those enrolled in managed care reside in one of the five, not-for-profit County Organized Healthcare Systems (covering eight counties). County Organized Healthcare Systems (COHS) require the "mandatory" enrollment of all Medi-Cal individuals. However, some people with disabilities who reside in counties with the Two-Plan Model (twelve urban counties) or Geographic Managed Care Model (Sacramento and San Diego) have voluntarily enrolled in Managed Care.

Subcommittee Staff Recommendation. It is evident that the DHCS needs encouragement in order to proceed with the actual development and implementation of performance standards appropriate for serving people with special needs, including individuals who are elderly, have significant chronic conditions or are disabled.

In technical assistance discussions with various entities regarding this topic, several ideas were discussed.

First, it is recommended for the DHCS to craft an action plan for proceeding with short-term and longer-term steps. **Therefore, the following Budget Bill Language is proposed**:

> Item 4260-001-0001.
> "The Department of Health Care Services (DHCS) shall develop an action plan which specifies both short-term and longer term goals for implementing performance and quality assurance measures within the Medi-Cal Program using the department's May 2007 draft report, which responds to the California Healthcare Foundation's recommendations, as a guide. The DHCS will consult with diverse constituency groups, as deemed appropriate, as well as with other state departments which provide services to individuals with special health care needs, in the development of this action plan. It is the intent of the Legislature for this action plan to be used as a tool to improve the Medi-Cal Program and for it to be a working document that is updated and shared intermittently, at least semi-annually, with interested parties as applicable.

Second, it was noted that "care coordination" is a major them throughout the CA Healthcare Foundation Report. This has also been an issue that has been raised regarding the Agnews Developmental Center closure discussions as well. The DHCS has informed Subcommittee staff that many of the "care coordination" recommendations (see the "cross-cutting issues", "care management", "quality improvement", "performance measures" and "coordination of carve out services" sections of the report) could be addressed if the DHCS obtained additional resources. Therefore it is recommended to provide the DHCS with three positions for this purpose. **These positions include the following: (1)** a Nurse Consultant III; **(2)** a Health Education Consultant; and **(3)** a Research Program Specialist.

In order to fund these three positions, it is recommended to **redirect** $325,000 in federal Title V Maternal and Child Health to be used for this purpose (with some travel expenses).

Specifically, the Administration is proposing to increase by $2 million, or by 42 percent in one year, the amount of federal Title V Maternal and Child Health (MCH) funds to be allocated to selected counties. For the 2005-06, and 2006-07, selected counties received a total of $7.4 million ($4.7 million federal MCH funds). However for 2007-08, the Administration proposes an increase of $2 million (federal MCH grant funds) for a total expenditure of $9.4 million for the counties.

Given the need to "jump start" the DHCS regarding the report recommendations, and the fact that a portion of federal MCH funds are to be used to provide assistance to the disabled population, redirecting a portion of these funds for this purpose seems reasonable. Further, the Administration's significant increase to the counties has not been justified.

Third, the DHCS would benefit from hiring a consultant (s) to assist them with three areas of focus as outlined below (and as referenced in the report under the "cross cutting issues" section):

- Develop a statewide education plan, training curriculum (or identify appropriate existing curricula) and materials to ensure that health plan, provider and state staff can provide services that are culturally competent and sensitive to the needs of individuals with disabilities and chronic conditions.
- Improve the initial health assessment. This would assist in preventing the disruption of ongoing care currently provided in the Medi-Cal Fee-for-Service Program when persons with disabilities move to Medi-Cal Managed Care.
- Enhance the facility site review tool, specifically targeting access for individuals with disabilities

Based on the needs identified above, it is recommended **to provide $450,000 in *redirected* federal Title V MCH funds for a two-year period** to facilitate completion of the above items. The following Budget Bill Language is proposed for this purpose:

> Item 4260-001-0001
> "Of the amount appropriated in this item, up to $450,000 (transferred from Item 4260-111-0890) may be used for purposes of establishing interagency agreements or contracts, or combinations thereof, to proceed with implementation of the recommendations contained within the Department of Health Care Services (DHCS) May 7, 2007 draft report regarding performance and quality standards for the Medi-Cal Program. It is the intent of the Legislature for recommendations regarding the crafting of a statewide education plan, improving the initial health assessment and enhancing the facility site review tool to receive a priority focus. The DHCS may seek the assistance of foundations and other sources of funds to facility stakeholder involvement in these activities and other matters which pertain to the May 7, 2007 draft report.

These recommendations would redirect a total of $775,000 (federal Title V MCH Funds) for 2007-08 and 2008-09, with ongoing expenditures of $325,000 (federal Title V MCH Funds). It should be noted that the remaining amount of the Administration's federal Title V MCH Funds, or $1.225 million, would be provided to the counties.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, When will additional work be completed in this area? (The Medi-Cal Program was provided resources in the Budget Act of 2005 and 2006 for specific follow-up work in this area.)
2. **DHCS**, From a "technical assistance" perspective, please comment on how additional resources would facilitate progress.

5. Rate Increases for Medi-Cal Managed Care Plans

Prior Subcommittee Hearing. In the Subcommittee's April 16th hearing, the "Mercer Report" recommendations on how to restructure Medi-Cal Managed Care rates was discussed at length. Public comment regarding concerns with the low reimbursement, lack of transparency in the rate making process and related concerns were received.

Governor's May Revision. The May Revision proposes **three key changes** to the capitated rates paid to Medi-Cal Managed Care Plans and its process.

First, an overall increase of $214.3 million ($107.1 million General Fund) is proposed for the capitated rates. The DHCS states that this proposed increase is based on the plan-specific, experienced-based rate methodology developed as the result of the Mercer Report.

It should be noted that 50 percent of the total proposed increase, or $106.3 million ($53.1 million General Fund), is budgeted to **"hold harmless"** health plans for one-year from any negative results of the revised rate methodology. The DHCS states that consistent with past practices when changing rates or rate methodologies, the Administration is maintaining capitation payments for certain health plans at the 2006-07 levels for one year (i.e., through a one-year contract period). It should be noted that this dollar amount is an estimate.

The actual rates to be paid to each Medi-Cal Managed Care participating health care plan will *not* be determined until after the budget is enacted. The DHCS intends to meet with each plan to discuss and negotiate the actual rates based on available data and analysis. However, the DHCS did provide the following information as an *informational guide* to how the pool of increased funds may generally divide between plan models; this is shown below. (Plan models have different contract time frames which affect the expenditures on the natural due to timing across fiscal years).

Informational Display of May Revision Medi-Cal Managed Care Rate Increase

Type of Plan	2007-08 Increase (Includes Hold Harmless)	Estimated Annual Cost (*No* Hold Harmless)
County Organized Health System (Rate Year: July 1 to June 30)	$63.6 million	$63.6 million
Two-Plan Model (October 1 to September 30)	$131.8 million	$175.7 million
Geographic Managed Care—Sacto. (January 1 to December 31)	$6.3 million	$12.6 million
Geographic Managed Care—San Diego. (January 1 to December 31)	$12.6 million	$12.6 million
TOTAL RATE INCREASE	**$214.3 million**	**$264.5 million**

Second, it should be noted that the DHCS is implementing ***some*** of the recommendations of the Mercer Report in 2007-08 but ***not*** **all of the recommendations.** The Administration states that due to factors such as timing and the required data processing and analysis of some aspects of the Mercer recommendations, 2007-08 is a transitional year. Further they note that the DHCS will implement the remaining recommendations targeted for adoption in "future" years.

Specifically, the DHCS states that the following **key** components of the Mercer Report recommendations for Medi-Cal Managed Care rates are to be implemented in 2007-08 and that the proposed rate increase includes these factors:

- Utilization of a county and plan specific, rate development process based on:
    - Health plan specific encounter and claims data;
    - Supplemental utilization and cost data submitted by the health plans;
    - Fee-for-Service data for the underlying county of operation or adjoining counties if deemed necessary;
    - Department of Managed Health Care financial statement data for Medi-Cal Operations; and
    - In absence of actual plan data—substitute plan model, similar plan, and/or county specific Fee-For-Service data.
- Inclusion of administrative costs as a percentage of the total capitation. The methodology will apply a different percentage for administration against different aid code groupings (e.g., family versus aged, blind and disabled).
- Development of rates that include a combined assumption of two percent for underwriting, profit risk and contingency. The intent of this adjustment is to maintain a health plan's financial solvency in lieu of a "tangible net equity" (TNE) adjustment.
- Use of a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates and as part of the overall financial monitoring of the plan.
- No "budget adjustment factor" is applied.

The key components of the Mercer Report that are not included for 2007-08 are as follows:

- No maternity supplemental payment (a "kick payment") to cover the cost of all deliveries. The kick payment is intended to normalize health plan risk and covers perinatal services through the first 2 months after the child's birth. The DHCS hopes to proceed with this in 2008-09.
- No Pay-for-Performance Incentive Program. The DHCS hopes to proceed with this in 2008-09.
- No mechanisms to measure the relative risk of each health plan to identify adverse population selection is included in the rate methodology.

Third, the Administration is proposing trailer bill language to transfer the authority to establish Medi-Cal Managed Care rates to the Department of Health Care Services (DHCS) from the CA Medical Assistance Commission (CMAC) for the County Organized Health Systems (COHS) participating in the Medi-Cal Managed Care Program. Presently CMAC provides the rate information to the COHS.

Background—Overview of Medi-Cal Managed Care. The DHCS is the largest purchaser of managed health care services in California with over 3.2 million enrollees, or about 50 percent of enrollees, in contracting health plans.

The state's Managed Care Program now covers 22 counties through three types of contract models—Two Plan Managed Care, Geographic Managed Care, and County Organized Health Systems (COHS). Twenty health plans have contracts with Medi-Cal within the 22 counties. Some of the plans—like commercial plans—contract with Medi-Cal under more than one model (i.e., commercial plan in Two Plan Model and participate in the Geographic Managed Care model for example).

For people with disabilities, enrollment is mandatory in the County Organized Health Systems, and voluntary in the Two Plan model and Geographic Managed Care model. About 280,000 individuals with disabilities are enrolled in a Medi-Cal Managed Care plan.

Each of these models is briefly described below.

- *Two-Plan Model.* The Two Plan Model was designed in the 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.

- *Geographic Managed Care Model.* The Geographic Managed Care model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. Sacramento and San Diego counties contract with nine health plans that serve about 11 percent of all Medi-Cal managed care enrollees in California.

- *County Organized Healthy Systems (COHS).* Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for **all** Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher costs aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models. About 550,000 Medi-Cal recipients receive care from these plans. This accounts for about 16 percent of Medi-Cal Managed Care enrollees.

Constituency Concerns. The Subcommittee is in receipt of letters that support the rate increase but also are seeking further clarity from the Administration as to how the rates were calculated and as to the process and timing of the final rate determinations by health plan for the specific Medi-Cal populations (e.g., family, child, and aged, blind and disabled).

Legislative Analyst's Office. The LAO expresses concern regarding the "hold harmless" provision of the Administration's proposed rate increase.

Subcommittee Staff Recommendation. It is recommended to **(1)** approve the increase of $214.3 million ($107.1 million General Fund); **(2)** adopt placeholder trailer bill legislation to codify the Administration's proposed rate methodology changes; and **(3)** transfer the authority to establish Medi-Cal Managed Care rates to the DHCS for the Geographic Managed Care Model (Sacramento and San Diego), in addition to the COHS.

The purpose of the placeholder trailer bill language is to ensure that state statute contains a framework of the rate structure to be used for Medi-Cal Managed Care.

In addition, it makes absolutely no sense to have the CMAC involved in any aspect of establishing rates for Medi-Cal Managed Care. It is the DHCS that has and best understands the data. It is the DHCS that will be working with all of the other Medi-Cal Managed Care models. There has been confusion caused in the past by the overlapping roles and responsibilities related to the CMAC and DHCS in developing rates for COHS as well as Geographic Managed Care (GMC) plans. One state department needs to be in charge and be accountable; this should be the DHCS for it all.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a full description of the proposed rate increase, the key components of the new rate methodology, and why the hold harmless provision is important for 2007-08.
2. **DHCS**, Please briefly describe the Administration's trailer bill language.

6. Personalized Provider Directories for Medi-Cal Managed Care—Trailer Bill

Prior Subcommittee Hearing. In the April 30th hearing, the Subcommittee discussed the Administration's January proposal for trailer bill language to save $2 million ($1 million General Fund) by changing how the Medi-Cal Managed Care Program structures the provider directories provided to each person enrolling into a Medi-Cal Managed Care Program. The savings assumed by the DHCS are from a reduction in paper, printing, provider directory packet assembly and postage costs.

The Administration's proposal was very broadly crafted and needed much more discussion with the involved constituency groups.

The Subcommittee held this issue "open" to enable the DHCS to work with health care plans, and consumer advocacy organizations to craft a revised proposal to have the Medi-Cal Program "pilot" the personalized provider directory in two counties, with one of them being Los Angeles.

Governor's May Revision. The May Revision savings level for the Administration's proposal has now been reduced to be a savings of only $1,150 dollars. In addition, the Administration has been working with constituency groups to craft a two-county pilot project for this purpose.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recognized that Medi-Cal enrollment materials, including materials regarding the choice of Managed Care plans, need to be streamlined and simplified.

In an effort to continue the discussions to see if a compromise can be obtained, it is recommended to adopt placeholder trailer bill language that would have the following components:

- Provide for a two county pilot for two years. (Most likely to be Los Angeles and Sacramento).
- Make sure that the directories are truly "personalized" for consumer ease as well as to ensure that health care plans can distinguish themselves from each other.
- Each plan would have its own, *consolidated*, provider booklet.
- Prior to implementation, the DHCS would have to further consult with stakeholders regarding the parameters of each pilot and how to evaluation the outcomes from it.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. **DHCS,** Please provide a brief update as to where the discussions are regarding conducting a two county pilot project. Would more time be useful to see if a compromise can be achieved?

7. Trailer Bill Language For Quality Improvement Fee for Medi-Cal Managed Care

Governor's May Revision. The Administration is proposing trailer bill language that would **(1)** extend the sunset date for the Quality Improvement Fee on Medi-Cal Managed Care plans from January 1, 2009 to October 1, 2009 to correspond to the timeline established in the federal Deficit Reduction Act of 2005 (DRA); and **(2)** adjust the amount of the Quality Assurance Fee from its current 6 percent to 5.5 percent as required by the federal DRA.

The fiscal affect of this change is that $10.1 million (total funds) will be reduced from the baseline Medi-Cal Managed Care funding level.

The DHCS increased payments to Medi-Cal Managed Care plans by drawing down federal matching funds to reimburse plans for a 6 percent Quality Improvement. Managed Care plan rates were adjusted to include this in their rates on their anniversary dates beginning July 1, 2005. Effective January 1, 2008, the Quality Improvement Fee will drop from 6 percent to 5.5 percent.

Subcommittee Staff Recommendation. It is recommended to adopt the trailer bill language as proposed by the Administration. It would conform state law to federal DRA changes. No issues have been raised.

Questions. The Subcommittee has requested the DHCS to respond to the following question.

1. **DHCS**, Please provide a *brief* summary of the need for this trailer bill language.

8. Administration's Trailer Bill Language-- AB 1629 Nursing Home Rates

Prior Subcommittee Hearing. In the April 16th hearing, the Subcommittee discussed the Administration's proposal to reduce Medi-Cal reimbursement for nursing homes and left the issue "open", pending receipt of the May Revision.

Governor's May Revision. The May Revision continues the Administration's proposal to modify Assembly Bill 1629 (Frommer), Statutes of 2004, which implemented a facility specific rate setting system for facilities providing long-term care services (nursing homes).

Specifically, the Governor's May Revision does the following:

- **First, it reduces by $32.6 million** ($16.3 million General Fund) the amount paid by adjusting the maximum annual rate increase or "growth cap" to 4.5 percent, instead of the presently required 5.5 percent as contained in statute. The proposed 4.5 percent growth cap would be effective as of August 1, 2007. The Administration contends this change is necessary due to recent federal law changes regarding "Quality Assurance Fees", as well as an overall need to reduce General Fund expenditures.

- ***Second,*** it would provide that beginning with the 2008-09 rate year, the maximum annual increase in the weighted average Medi-Cal rate for nursing homes would be adjusted based on a "medical" consumer price index (language needs to be fixed), and not by other factors as presently contained in statute. **This aspect of the proposal would reduce and flatten-out future rate increases for nursing homes.**

- ***Third***, the Administration would extend the sunset date for this nursing home rate methodology by one year, from July 31, 2008 to July 31, 2009.

Background---Summary of Key Aspects of Assembly Bill 1629 (Frommer), Statutes of 2004. This legislation created a *"facility-specific"* Medi-Cal reimbursement methodology for nursing homes, and authorized a provider *"Quality Assurance Fee"* to assist in providing a Medi-Cal rate increase.

The purpose of these changes were to devise a rate-setting methodology that: (1) encouraged access to appropriate long-term care services; (2) enhanced quality of care; (3) provided appropriate wages and benefits for nursing home workers; (4) encouraged provider compliance with state and federal requirements; and (5) provided administrative efficiency.

The key components of the nursing home rate methodology contained in this enabling legislation are as follows:

- Establishes a **baseline reimbursement rate** (weighted average rate) *and* state maintenance of effort level (methodology in effect as of July, 2004 plus certain specified adjustments). (The facility-specific rate and "Quality Assurance Fee" rate increases are built upon this baseline.)

- Establishes a **"facility-specific" Medi-Cal reimbursement methodology** for nursing homes. Payment is based upon each facility's projected costs for five major cost categories: (1) labor costs; (2) indirect care non-labor costs; (3) administrative costs; (4) capitol costs—"fair rental value system"; and (5) direct pass-through costs (proportional share of actual costs, adjusted by audit

findings).

- Imposed a **"Quality Assurance Fee"** on all nursing homes (about 1,200 facilities), not to exceed 6 percent, which is deposited in the state treasury and is used to fund the specified rate increases, as well is used to offset some General Fund expenditures (amounts vary each year for the rate increase and General Fund savings levels).

- Limits growth in the overall Medi-Cal reimbursement rate for nursing homes through the use of spending caps. These spending "caps" were agreed to because facility-specific reimbursement systems can be inflationary. The spending "caps" contained in the enabling legislation are:

  - ✓ 2005-06 8 percent (of the weighted average rate for 2004-05);
  - ✓ 2006-07 5 percent
  - ✓ 2007-08 5.5 percent **(note: Administration wants to reduce to 4.5 percent)**

Background—"Quality Assurance Fees" and the Federal Changes. California presently uses a "Quality Assurance Fee" for the "AB 1629" nursing home rate methodology, as well as within the Medi-Cal Managed Care Program. These fees are collected from providers on a quarterly basis and are used by the state to obtain additional federal funds to provide rate increases for these two areas. In addition, net General Fund revenues (savings) are obtained from these actions. **Effective January 2008, the federal government is lowering the 6 percent threshold for fees to 5.5 percent.**

Constituency Concerns with Governor's Proposal. The Subcommittee is in receipt of letters from industry organizations, labor organizations and others expressing considerable concern with the Administration's proposal. The key concern is the reduction to the reimbursement rate (by lowering the spending cap to reduce the percentage of rate increase).

Organizations state that this reduction undermines the basis for the "Quality Assurance Fee". They contend that the industry and labor have been assuming a certain level of rate adjustment for the upcoming year based upon the existing statute. As such, the proposed reduction would be problematic.

Subcommittee Staff Recommendation—Reject Rate Reduction. It is recommended to **(1)** increase by $36.6 million ($16.3 million General Fund) to restore the nursing home rates to the full 5.5 percent; **(2)** extend the sunset for the rate methodology for one-year; **(3)** reject the Administration's trailer bill language to change out year rate reimbursement calculations to use the "medical" consumer price index; and instead, adopt placeholder trailer bill language which would provide for a 4.5 percent increase using the Quality Assurance Fee *or* the medical cost-of-living increase, which ever is higher; and **(4)** extend the required evaluation report on the program for one-year in order to obtain more comprehensive data.

9. Proposed Trailer Bill—Enteral Nutrition Products *&* Medical Supplies

Prior Subcommittee Hearing. In the March 26th hearing, the Subcommittee discussed the Administration's proposal to adopt trailer bill language to more assertively pursue contracts for non-drug products offered under the Medi-Cal Program, including various medical supplies, incontinence supplies and enteral nutrition products.

The Administration's language proposed a framework to the contracting process including criteria for product selection. At the time of the Subcommittee hearing, it was not *clear* how this framework would be applied to the various products covered by the language. The January budget assumed a reduction of $8.4 million ($4.2 million General Fund) solely attributable to this proposed trailer bill language.

The Subcommittee held the issue "open" and urged the DHCS and constituency groups to discuss a potential compromise.

Governor's May Revision. The May Revision continues the January proposal as already outlined above, including the savings.

The DHCS states that they have expanded its management of the existing contracts for these non-drug products to include contracting for specific manufacturer products. They contend that the proposed trailer bill language change mirrors the model set by the department's drug-contracting program.

However, unlike drug contracting, state statute currently does not provide specific language that clarifies the process for these three categories (medical supplies, incontinence supplies and enteral nutrition products), nor does it recognize supplier costs for the dispensing and distribution of the medical supplies and enteral nutrition products.

Though the DHCS has not yet been able to reach a compromise with interested parties, they do want to continue discussions to see if a compromise can be reached. They have met with several different organizations and individual company representatives to engage in reaching a resolution with all involved parties, but require more time to work through the different issues.

Background—Medi-Cal Contracting (non-drug). The DHCS maintains the medical supply, enteral nutrition, and incontinence supply benefits that account for about $240 million in total expenditures annually. Existing statute enables the DHCS to contract for these different products. These non-drug product contracts can either be a rebate contract or a guaranteed acquisition cost (i.e., guarantees a provider will not pay more than the contract amount to obtain the product) or a combination of both.

Subcommittee Staff Recommendation—Adopt Place Holder Trailer Bill Language. The proposed language as originally crafted by the Administration in January was *very* broad and did not clearly provide appropriate patient protections that are often needed due to the number and diversity of special needs populations that the Medi-Cal Program serves.

The medical supply area is a large category that covers hundreds of different and diverse products. As such, it is imperative to ensure that statute does not inadvertently limit access

to special needs products.

In addition, consideration needs to be given regarding the dispensing and distribution of the medical supplies and enteral nutrition products so suppliers and providers are willing and able to participate in the contracting process. Further, an appeals process is also warranted.

The DHCS is making strides in negotiating trailer bill language with constituency groups. As such, it is recommended to adopt placeholder trailer bill language which would have the DHCS establish criteria on contracting with manufacturers, including the evaluation of products as medically necessary products, the specific rules for contracting, commitment to perform a dispensing study to account for product distribution costs, and to provide for an appeals process.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. **DHCS**, Please provide a *brief* update on working through the proposed language.

10. Proposed Reduction to Rates Paid to Pharmacists for Dispensing Drugs

Prior Subcommittee Hearing. In the March 26th hearing, the Subcommittee discussed the Administration's January proposal to reduce by $88 million ($44 million General Fund) in the Medi-Cal Program as it pertains to Pharmacists reimbursement.

The Department of Health Care Services' (DHCS) proposal consisted of **(1)** changing the existing payment structure for pharmacy reimbursement from the "Average Wholesale Price" (AWP) to an **"Average Manufacturer Price" (AMP); (2)** implementing a revised **"Federal Upper Payment Limit" (FUL);** and **(3)** recognizing an upcoming settlement agreement between the federal government and First Data Bank (the source of Medi-Cal's current pricing structure)**.** The proposed change requires trailer bill legislation to enact.

The Subcommittee held the issue **"open"** pending receipt of the May Revision.

Governor's May Revision. The May Revision continues the January proposal but now assumes a reduction of $77.4 million ($38.7 million General Fund) by moving the implementation date to September 2007 (one month later). This reduction level assumes that $100 million ($50 million General Fund) would be saved annually.

Unfortunately due to data limitations, the Administration is not able to provide fiscal information on how the reduction of $77.4 million is split between the three component parts of the proposal.

***However*, two of the Administration's proposed changes—the federal government's settlement with First Data Bank and the implementation of the revised Federal Upper Payment Limit (FUL)—will occur on the natural once the federal government has finalized the settlement and has completed regulations.**

The DHCS notes that First Data Bank and the federal government have agreed on a settlement that is expected to reduce the existing "Average Wholesale Price" for many single-source (brand name drugs) by about 5 percent. California's Medi-Cal Program, like many states, uses First Data Bank as its source for determining Medi-Cal's current pharmacy pricing structure of Average Wholesale Price minus 17 percent (AWP minus 17 percent).

At this time, it is not fully clear as to when the federal CMS will complete its regulations on the FUL but the DHCS anticipates that the revised FUL will be lower than the current FUL.

The **third aspect** of the Administration's proposal is where the DHCS is proposing a broader change to the Pharmacy reimbursement structure which would move all drugs from the existing AWP minus 17 percent to an Average Manufacturer's Price based mark-up in an effort to reduce drug reimbursement costs. **Once the federal Average Manufacturer's Price information is available, the DHCS will be able to make the Pharmacy reimbursement structure change.**

No adjustment to the Pharmacy dispensing fee is proposed by the Administration at this time. However, the department is presently using a contractor to conduct a study of Pharmacy dispensing fees. Unfortunately, this study will not be completed until June or later. This makes it difficult for the Legislature to respond to any needs for a dispensing fee within the budget timeline constraints.

Pharmacy Reimbursement in the Medi-Cal Program. The pharmacy reimbursement consists of two components—a drug ingredient cost and a dispensing fee. Generally, the drug ingredient cost constitutes about 85 percent of the payment per prescription to a pharmacy. The proposed reduction would reduce the amount paid for drug ingredient costs.

The existing pharmacy dispensing fee is $7.25 per prescription except for long-term care pharmacies which receive $8.00 per prescription.

Background—Federal Deficit Reduction Act of 2005 and Medicaid Pharmacy Changes. Among other things, the federal Deficit Reduction Act (DRA) made changes to the Medicaid (Medi-Cal) prescription drug program as it pertains to Pharmacy reimbursement. **The first change pertains to the "Average Manufacturer Price" (AMP).**

Prior to the DRA changes, the AMP was *solely* used by the federal government to calculate and determine the federal drug rebate. The AMP was calculated for each drug of a manufacturer and reported on a quarterly basis to the federal CMS. This *confidential* information was used to calculate federal drug rebates.

Under the DRA, drug manufacturers will have to abide by specific rules on the calculation of the AMP and will be required to report this information on a monthly basis, as well as on a quarterly basis. The federal CMS will use this information to calculate the federal drug rebates (as before) *and* to create new "federal upper limit" (FUL) prices. **The AMP will now be public and will be provided to all state Medicaid programs.**

The federal CMS has informed state Medicaid programs to use the monthly AMP information, when it becomes available, as well as retail price survey information to assess their pharmacy reimbursement rates, including the dispensing fees.

The second change pertains to the "federal upper limit" (FUL). The federal CMS establishes a FUL for generic drugs based on certain criteria. Prior to the DRA changes, a FUL price was calculated using price information obtained from pricing companies (such as First Data Bank) and was generally calculated based on three or more generically equivalent drugs on the market. The DRA changes how the FUL is calculated by requiring there to be only two generically equivalent drugs available on the market and by using the AMP in the calculation. **The affect of this change is that the FUL will decrease the reimbursement rate for generic drugs.**

Constituency Concerns. The Subcommittee is in receipt of constituency concerns from retail pharmacy representatives that the proposed changes would create a hardship on providers if the AMP reduction to the drug ingredient is enacted with no recognition of a need to increase the dispensing fee. They do not believe that the AMP is an accurate measure of

drug costs and are very concerned that pharmacies will be hit with substantial cuts and will drop out of the Medi-Cal Program.

As such, the Pharmacy industry is seeking an increase to the existing dispensing fee to assist in off-setting some of the other pending federal actions.

Subcommittee Staff Recommendation. In lieu of the Administration's full proposal, it is recommended to **(1)** recognize savings of only $57.4 million ($28.7 million General Fund), or $20 million (total) less than proposed by the Administration; **(2)** adopt place holder language that authorizes the Administration to proceed with implementation of the Average Manufacturer's Price once it is available from the federal government; and **(3)** adopt placeholder language that within 30-days of the implementation of the Average Manufacturer's Price, the DHCS shall recalculate the Pharmacy dispensing fee and implement the recalculation.

The recommended reduction in the amount of savings is a ballpark estimate of the level of savings that may be offset due to increasing the dispensing fee accordingly, as provided for in the place holder trailer bill language. Since the Administration's calculation is also an estimate of the three components, a reduction of $20 million seemed reasonable.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. **DHCS,** Please provide a brief summary of the three components to the proposal and a brief update as to where things are with the federal government.
2. **DHCS**, Please explain how the Average Manufacturer Price is different than the Average Wholesale Price minus 17 percent. Why does the federal government want to use the Average Manufacturer Price?

11. Need to Improve State's Responsiveness & Partnership with Counties

Prior Subcommittee Hearing. In the April 16th hearing, the Subcommittee discussed the Administration's trailer bill language proposal to increase the performance standards from a 90 percent compliance rate to a 95 percent compliance rate. The Administration's proposal does not assume any savings attributable to this language in the budget year.

The Subcommittee held **"open"** this trailer bill issue to see if any compromise could be achieved. *However*, the Subcommittee did concur with the County Welfare Director's Association (CWDA) that moving to a 95 percent level for county performance measures is unworkable at this time due to the need for the state to improve its own operations, as well as the need to implement the federal DRA requirements which will be quite difficult and should be focused on.

The CWDA presented information regarding the difficulties Medi-Cal eligibility workers have in their work due to the 1,000 page plus Medi-Cal eligibility manual, hundreds of "All County Letters" that contain instructions and other materials that must be search and analyzed to discern what the Medi-Cal rules are for making certain determinations for potential Medi-Cal enrollees.

Issue & Subcommittee Staff Recommendation. At the request of the Subcommittee, both counties and advocacy organizations have provided *numerous* concrete examples regarding Medi-Cal eligibility processing questions, interpretation issues regarding all county letters from the state, and the lack of regulations on many, many aspects of the Medi-Cal Program. Many of the, as yet unanswered, questions that have been posed to the DHCS are from several months to even *years* old.

In fact, there have been over 593 "all county letters" over the past 10 years which contain instructions to counties regarding Medi-Cal Program operations, there is the 1,000 plus page Medi-Cal Manual which is *not* current that county eligibility workers must use, and the last time that the DHCS completed any regulations on the Medi-Cal Program was in 1999. Three sources of information must be search and clarified in many instances for counties, as well as advocates, to understand the Medi-Cal Program. Plus there is state statue and federal law interpretation.

Clearly, the Medi-Cal Program needs to be a better business partner. The state needs to undertake a review of the Medi-Cal Program manual, regulations and all-county letters. Counties, as well as advocacy groups, should have clear instructions about how the program operates and the requirements they need to fulfill.

It is very ironic that the Administration wants to raise the performance standards on the counties when they themselves need more clarity and structure and as to how the program is to operate for it to be truly efficient and effective.

As such, it is recommended to trailer bill language regarding the states efforts to proceed with this should be part of any compromise language.

It is recommended to **add** the following trailer bill language to Section 14154.2 of the Welfare and Institutions Code as follows:

"(a) In order to help counties improve their Medi-Cal eligibility operations and to minimize confusion for counties and consumers regarding Medi-Cal eligibility rules and procedures, **the department shall do all of the following:**

(1) Provide counties with technical assistance and training, including but not limited to:

(A) Assisting counties that demonstrate a need for improvement on the performance standards contained in Section 14154.

(B) Assisting counties identified as needing improvement as a result of quality control reviews conducted by the department.

(C) Collecting, and making available to counties, training materials developed by counties, advocates and the state.

(D) Developing and implementing a simple method for receiving and responding to questions from counties, consumer advocates and other stakeholders regarding Medi-Cal eligibility.

(2) Develop and disseminate checklists for use by consumers and county staff to assist in the completion and processing of applications and annual redeterminations. Checklists for consumers shall be written at an appropriate reading level using consumer-friendly language and shall summarize what specific steps or information is required to complete the application or annual redetermination in no more than one page each.

(3) Identify and disseminate best practices with respect to:

(A) Promising business models for effective tracking and processing of applications and annual eligibility determinations.

(B) Effective ways of measuring county and staff performance and improvement on the performance standards contained in Section 14154.

(C) Implementing effective performance management strategies in an automated environment.

(D) Promising practices, tools, and materials to encourage and assist consumers in completing the application and redetermination processes, including practices that improve their success in enrolling and retaining Medi-Cal.

(4) To organize the complex Medi-Cal rules and procedures into a single comprehensive system, no later than July 1, 2010, the department shall complete the issuance of updated regulations related to Medi-Cal eligibility to reflect policies and procedures in all-county letters, the Medi-Cal Eligibility Procedures Manual and all other relevant instructions that have been issued to counties. These updates shall be adopted via the non-emergency regulatory process in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and shall be prioritized according to the following order:

(A) Changes affecting children and families.

(B) Changes affecting the aged, blind and disabled.

(C) Changes affecting the eligibility of groups not listed in (A) or (B).

(D) All other changes.

(b) The department shall consult with the County Welfare Directors Association and with consumer advocates in implementing this section.

(c) The department shall report annually to the Legislature at the time of budget hearings on its implementation of this section.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, How many employees does the Medi-Cal Program have in the Eligibility and Medi-Cal Policy Divisions? Can some of these resources, as well as other resources within the Medi-Cal Program, be used to improve the core structure of the program in this area?
2. **DHCS**, Please comment on the proposed trailer bill language.

12. Constituency Request for Trailer Bill Language for Conlan vs. Shewry

Issue. Constituency groups are concerned with the lack of clarity and consistency regarding existing state statute and the directions, or lack thereof, that the DHCS has provided regarding the state's "Conlan Plan" as a result of the Conlan vs. Shewry Court order.

Under the Conlan Plan, Medi-Cal has implemented a "beneficiary reimbursement" process by which Medi-Cal beneficiaries can obtain reimbursement of their Medi-Cal covered out-of-pocket expenses according to the terms of the Court order.

However, constituency groups have raised concerns with the implementation because existing state statute does not reflect the full contents of the Court order, and the they contend that the DHCS needs to ensure that the Conlan "beneficiary reimbursement" process is clear on a going forward basis. It is critically important for all involved parties to know what the rules of the Court order are and how they are to be fully implemented.

Background—*Conlan vs. Shewry*. Several departments are affected by this Department of Health Care Services lawsuit. This lawsuit has a long history resulting in the issuance of several court decisions.

To effectively implement the court ordered requirements of Conlan, the DMH must process claims from Medi-Cal beneficiaries who paid out-of-pocket expenses for Medi-Cal covered services received during specific periods of a beneficiary's Medi-Cal eligibility. **These periods include: (1)** the retroactive eligibility period (up to 3 months prior to the month of application to the Medi-Cal Program); **(2)** the evaluation period (from the time of application to the Medi-Cal Program until eligibility is established); and **(3)** the post-approval period (the time after eligibility is established).

The court has approved the DHCS revised implementation plan (i.e., Conlan Plan) which was effective as of November 16, 2006. As a result of this plan, about 12 million letters were sent to households in December 2006. Letters were sent to all Medi-Cal beneficiaries who had applied and were eligible at some point on or after June 27, 1997.

Subcommittee Staff Recommendation. It is recommended to adopt the following trailer bill language to address concerns with providing appropriate and timely information to the public regarding the implementation of Conlan.

It is recommended to *add* the following trailer bill language to Welfare and Institutions Code:

"(a) The Department of Health Care Services shall issue an All County Welfare Directors Letter and a Medi-Cal Provider Bulletin regarding the *Conlan v. Shewry* Beneficiary Reimbursement process no later than October 1, 2007 which will include at a minimum all of the following information:

(1) Persons eligible for Medi-Cal on or after June 27, 1997 are eligible for reimbursement of health care services paid out-of-pocket for Medi-Cal covered services during any of the following periods of time:

(A) the three months before an application for Medi-Cal was filed (retroactivity period);

(B) the time between when a Medi-Cal application was filed and was approved (evaluation period); and
(C) after being approved for Medi-Cal (post-approval period).

(2) Payments made to a Medi-Cal provider are eligible for reimbursement, including improper or excessive co-payments, improper share of cost amounts, or the cost of covered medical, mental health, IHSS, Drug & Alcohol or dental services.

(3) Payments made to non-Medi-Cal providers are eligible for reimbursement if the services were received either:

(A) On or before February 2, 2006 and the Medi-Cal eligible person had applied but not received a Medi-Cal card; or
(B) During the 90 day retroactivity period prior to the person filing of a Medi-cal application.

(4) Medi-Cal beneficiaries are entitled to reimbursement of the full amount paid, not limited to the Medi-Cal rate, if reimbursement is made by the provider or by the Department when it has the ability to initiate a recoupment action against a provider. If necessary, the Department will assist beneficiaries in attempting to obtain cooperation from the provider so that the full out-of-pocket amount is reimbursed.

(5) Providers who reimburse a Medi-Cal beneficiary may submit claims for payment to the Department for those services provided notwithstanding the billing timeliness limitations for claims submissions, [pursuant to Title 42 *Code of Federal Regulations*, Section 447.45(d)(1) and *California Code of Regulations* (CCR), Title 22, Division 3, Sections 51000.8(a) and 51008.5] even if more than twelve months has elapsed since the service was provided.

(b) The Department shall seek input from consumer advocates in developing the All County Welfare Directors Letter and the Provider Bulletin.

(c) The Department shall prominently post on its website information on the *Conlan v. Shewry* Reimbursement Process, including, at a minimum, the Conlan Implementation Plan that was approved by the Superior court."

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. **DHCS**, Please explain the key components of the Conlan Plan, and how the department is meeting the expectations of the Court and the Court approved Conlan Plan.
2. **DHCS,** Are all of the materials provided to counties, provider groups and constituency groups up-to-date regarding the Conlan Plan?
3. **DHCS,** Why doesn't the state want to change existing state statute at this point to conform to the Conlan Court order?
4. **DHCS**, Please explain the next steps in working with the federal CMS.

13. Trailer Bill:- Protection of DHCS Director's Right to Recover Medi-Cal Expenses

Prior Subcommittee Hearing. In the April 30th hearing, the Subcommittee discussed this issue and held it "open" to see if the language could be modified so that a compromise with constituency groups could be obtained and the Medi-Cal Program could collect on medical expenses.

Issue. In January, the Administration proposed trailer bill language as the result of a recent United States Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn* (2006) (Ahlborn) that held recovery of a personal injury lien for Medicaid services was limited to the portion of the settlement that represented payment for medical expenses.

The DHCS states that as a result of *Ahlborn*, there is no requirement that the portion of the settlement allocation dedicated to medical expenses be *sufficient* to repay the states' actual costs of providing the health care (through Medi-Cal). Therefore, settlements may be manipulated by others to claim that a minimal amount was allocated to medical expenses, or that medical expenses be waived altogether. As such the ability of the DHCS to participate in or to decide the reduction of the Medi-Cal lien could be circumvented, or recovery defeated altogether.

The DHCS contends that unless modified, settlement manipulation would benefit attorneys because more funds would be allocated to their client, versus repayment to the Medi-Cal Program for services rendered. Insurance carriers would also benefit because the pain and suffering portion of a personal injury settlement is routinely based on the scope and amount of medical treatment the injured party received.

Background. Both federal and state laws require the state to seek reimbursement of Medi-Cal funds expended on behalf of Medi-Cal enrollees when a third party is liable. This is because Medicaid (Medi-Cal) is a payer of last resort.

The DHCS Medi-Cal Program has a Personal Injury Recovery Program to mitigate Medi-Cal costs. The Director of the DHCS is required to seek recovery from third parties for Medi-Cal funds expended for injury-related services and to ensure that Medi-Cal is the payer of last resort. The Personal Injury Recovery Program identifies the third parties and recovers Medi-Cal expenditures by asserting claims for the state in personal injury tort actions. Half of all recovered funds are returned to the General Fund, and the other portion is returned to the federal government (since they provide the match).

Existing state law provides a framework for applying the personal injury recovery process. Section 14124.72 (d) requires a 25 percent reduction of the state's claim plus a pro-rated share of litigation costs, which represents the state's reasonable share of attorney fees when a Medi-Cal recipient obtains legal representation for his or her personal injury case. Section 14124.78 requires the state to reduce its claim to half of the net settlement amount, which permits the Medi-Cal recipient to receive the other half of the settlement. This statute provides a monetary incentive for Medi-Cal recipients to pursue a settlement for his or her personal injury case. The net amount is the remainder of the settlement *after* deducting the

full amount of the attorney's fees and litigation costs.

Subcommittee Staff Recommendation—Approve Modified Version. The DHCS contends that the Medi-Cal Program could potentially loose $22 million (General Fund) annually from not recouping on personal injury actions that pertain to a Medi-Cal enrollee and a third-party judgment.

In discussions with constituency groups, the DHCS provided revised language in an effort to obtain a compromise. The primary area of contention appears to be the amount of payment for future loss.

Though the language has not been fully fleshed out, it is recommended to adopt the modified DHCS version of the language to keep discussions going to the Joint Budget Conference Committee.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. **DHCS,** Please provide a summary of how the Medi-Cal lien process works now when a third-party judgment is involved, and how the *Ahlborn* case changed this process.
2. **DHCS**, Please then explain how the modified trailer bill language then enables the state to obtain recovery of funds.

D. Item 4300 Department of Developmental Services *(Discussion Items)*

Community-Based Services Provided through Regional Centers

1. Proposed Changes to Intermediate Care Facilities (ICF)—DD Bundled Rate

Prior Subcommittee Hearing In the Subcommittee's April 9th hearing, the Governor's January proposal to reconfigure the rate paid to Intermediate Care Facilities for persons with Developmental Disabilities (ICF-DD), including Habilitative (H) and Nursing (N) by cost shifting about $44 million in General Fund support to federal fund support was discussed.

Through discussions with constituency groups during the Subcommittee hearing, the following key concerns were noted:

- The Administration needed to ensure that the Individual Program Plan (IPP) process, as guaranteed under the state's Lanterman Act, would remain intact and not be jeopardized in any manner by the bundling of this rate. (i.e., Consumers need to receive their appropriate services as contained within the IPP.)
- The Administration needs to involve the stakeholders, including provider groups and consumer groups, as well as consumers and their families as appropriate, in the design of the process, including the contents of the State Plan Amendment.
- The Administration needed to provide all involved parties with a work plan as to how this proposal was going to proceed.

In response to the third issue, the Administration has provided the following timeline as requested for implementation:

• April 25, 2007	Stakeholder meeting conducted.
• April 30, 2007	Begin work on State Plan Amendment.
• May 31, 2007	Publish federally required notice of intent to revise ICF-DD rates to capture federal financial participation for Day Programs and Transportation Services.
• June, 2007	Share draft State Plan Amendment with Stakeholders.
• July 1, 2007	Submit State Plan Amendment to federal CMS.

Governor's May Revision. The May Revision makes a technical correction to the savings level proposed for the ICF-DD bundling by assuming a total *savings* of $44 million of which $36.6 million is General Fund and $8.4 million is Public Transportation Account. Otherwise, no other changes are proposed.

Additional Background on the Administration's Proposal to Bundle the ICF-DD Rate. Specifically, in order to capture additional federal funds, the state would have to redefine the ICF-DD facilities as an "all inclusive service" under the California's Medicaid (Medi-Cal) State Plan. Under the Administration's January proposal, ICF-DD facilities would be responsible for providing Day Programs, transportation, and other assistance (in cases where generic

services are unavailable). In turn, these services would be reflected in the rates paid to the ICF-DD facilities. Presently, these above described services are *not* part of the ICF-DD rate and are separately paid for by Regional Centers.

Federal regulations allow for a broad definition of the services that can be provided in ICFs with reimbursement under Medi-Cal. Therefore, by using this "all inclusive service" definition, the state can obtain more in federal funding and can subsequently, reduce state General Fund support by the same amount.

The Administration must submit a "State Plan Amendment" (SPA) to the federal government for approval prior to receipt of any additional federal funds for this purpose. The DHS, as the entity that manages the state's Medicaid Program (Medi-Cal), must submit the SPA. According to the DHS, they intend to submit the SPA to the federal government by no later than September 30, 2007 which should allow for California to claim additional federal funds for services rendered on or after July 1, 2007. (The federal government allows state to retroactively claim up to 3 months, or one quarter.)

Background—Role of the DHS and Description of Intermediate Care Facilities (ICF)-DD Services. The Department of Health Services (DHS) licenses three types of Intermediate Care Facilities that are available for individuals with developmental disabilities, depending on the nature of their health care needs. These facilities qualify for Medicaid (Medi-Cal) reimbursement for all people in the facilities who are eligible for Medi-Cal. The three facilities affected by the Administration's budget proposal are briefly described below:

- *ICF-DD*. Generally, these facilities provide developmental, training, Habilitative, and supportive health services to individuals who have a primary need for developmental services and a recurring but intermittent need for skilled nursing services. These facilities have certified capacities of 16 people or larger.
- *ICF-DD-H (Habilitative).* Generally, these facilities provide personal care, developmental, training, habilitative and supportive health services for children and adults with developmental disabilities who have a primary need for developmental services and an ongoing, predictable, but intermittent need for skilled nursing services. These facilities have certified capacities from 4 to 15 people.
- *ICF-DD-N (Nursing).* Generally, these facilities provide nursing supervision, personal care, developmental, training, habilitative and supportive health services to medically fragile children and adults with developmental disabilities who have a need for skilled nursing services that are not available through other 4 to15 bed health facilities. These facilities have certified capacities from 4 up to 15 people.

Subcommittee Staff Recommendation—Budget Bill Language & May Revision. In response to issues raised by constituency groups, Subcommittee staff has crafted Budget Bill Language as shown below to be placed within Item 4260-001-0001 (Department of Health Care Services) *and* Item 4300-101-0001 (Department of Developmental Services) to address these concerns. **The proposed recommended language is as follows:**

> "It is the intent of the Legislature for the Department of Health Care Services (DHCS) and Department of Developmental Services (DDS) to collaboratively work with stakeholders, including providers and diverse constituency groups as deemed appropriate, regarding the bundling of rates for the reimbursement of Intermediate

Care Facilities (ICF) for the Developmentally Disabled (DD), including Habilitative and Nursing facilities. It is the intent of the Legislature that any changes made by the state shall be seamless to the providers of services affected by the changes, as well as to the consumers and their families that are provided services through the Regional Center system. The integrity of the Individual Program Plan process, as contained in the state's Lanterman Act, shall be maintained throughout this process and shall not be affected by any changes made to implement the bundled rates."

It is also recommended to approve the Administration's technical funding adjustment, but to *use General Fund support* of $128.8 million in lieu of the Public Transportation Account funding.

Questions. The Subcommittee has requested the DDS and DHCS to respond to the following question.

1. **DDS and DHCS**, Please provide a *brief* update on this project and a *brief* explanation of the technical May Revision adjustment.

2. Administration's May Revision Estimate for the Regional Centers (Issues 200, 106, 107 and 202)

Prior Subcommittee Hearing. In the Subcommittee's April 9th hearing, a comprehensive discussion was had regarding the budget for the Regional Centers.

Many issues were discussed, including **(1)** the full-year effect of rate increases that were provided in the Budget Act of 2006 (i.e., a 3 percent across-the-board increase, as well as considerable increases for certain employment programs); **(2)** the Administration's proposal to continue specified "cost containment" measures for 2007-08; and **(3)** the full-year effect of the increases for the minimum wage.

Governor's May Revision Total Expenditures for the Regional Centers. The May Revision proposes total expenditures of $3.6 billion ($2.2 billion General Fund), a *net* increase of $35.6 million ($35.9 million General Fund) over the January budget, for community-based services provided through the Regional Centers (RCs) to serve a total of 219,230 consumers living in the community.

This funding level includes $497.1 million for RC operations and $2.7 billion for the "Purchase of Services". The consumer caseload reflects an estimated reduction of 1,370 consumers as compared to the January estimate.

Most of the May Revision increase is attributable to (1) an increase in the base utilization of services by consumers and updated expenditure data ($30.1 million increase); and **(2)** updated expenditure data to place individuals living at Agnews Developmental Center into the community and to deflect individuals who have been referred to the Developmental Center system for admission ($6.5 million).

The May Revision also reflects a reduction of $3.9 million (total funds) for Regional Center Operations due to the reduction in anticipated caseload as compared to the January budget.

The May Revision also reflects the following policy changes:

- *Dual Agency Foster Care Rates and Adoption Assistance*. As discussed in the Subcommittee's hearing on Monday, May 21st, the Department of Social Services has revised its rate-setting methodology for the care and supervision of foster and adoptive children receiving services from both County Social Services Departments and Regional Centers. The new methodology would place a rate cap of $2,006 per month, prospectively, which would ensure that a comprehensive and equitable rate-setting methodology is used throughout the state. This will result in a cost shift to the Regional Centers for services and supports when the rate cap is implemented. The phased-in impact to the DDS of this cost shift for 2007-08 is $100,000 ($74,000 General Fund). The action to be taken today is to conform to the May 21st Subcommittee hearing.

- *Self Directed Services Adjustments.* The May Revision proposes a series of adjustments which are primarily due to a later implementation date (March 1, 2008 versus January 1, 2008). It is assumed that 400 individuals will enroll in 2007-08 and that an average of $500 per consumer will be provided for person-centered planning and development of the

consumer's individual budget.

The Self Directed Services Program enables consumers to have more control of their services and to manage a finite amount of funds allocated in an individual budget in order to pay for services specified in the consumer's Individual Program Plan (IPP). Intensive person-centered planning is required to develop an IPP and individual budget reflective of a consumer's need. Subcommittee staff believes that these adjustments are reasonable.

Governor's May Revision—Purchase of Services for the Regional Centers. The May Revision for the "purchase of services" reflects total expenditures of $3.1 billion (total funds) as noted in the summary chart below. This reflects an increase of $39.5 million (total funds) over the January budget for 2007-08.

As compared to the revised current-year amount, the May Revision for 2007-08 represents an increase of about $287.3 million (total funds) or an increase of 10.3 percent in one year.

Summary of RC Purchase of Services Funding for 2007-08 (Total Funds)

Service Category	January 2007-08	May Revision 2007-08	Difference (Total Funds)
Community Care Facilities (CCFs)	$769.7 million	$782.5 million	$12.8 million
Medical Facilities	$17.8 million	$22.8 million	$5 million
Day Programs	$754.2 million	$763.4 million	$9.2 million
Habilitation Services	$150 million	$150.6 million	$600,000
Transportation	$214.6 million	$212.4 million	-$2.1 million
Support Services	$550.8 million	$551.3 million	$600,000
In-Home Respite	$180.5 million	$188 million	$7.5 million
Out-of-Home Respite	$48.3 million	$54.6 million	$6.3 million
Health Care	$91.4 million	$84.5 million	-$6.9million
Miscellaneous	$311.8 million	$318 million	$6.2 million
Early Start Program	$20.1 million	$20.1 million	--
ICF-DD Bundled Rate Adjustment	-$44.0 million	-$44.0 million	--
Dual Agency for Foster Care	N/A	$107,000	$107,000
Self Directed Services Adjustment	-128,000	$137,000	$265,000
Total POS Estimate (rounded)	**$3.045 billion**	**$3.084 billion**	**$39.5 million**

The May Revision continues the Governor's cost containment measures as proposed in his January budget and as discussed in the Subcommittee's April 9th hearing. **These cost containment actions have been previously adopted by the Legislature in lieu of more sweeping and restrictive actions previously proposed by Governor Davis and Governor Schwarzenegger.**

- *A. Delay in Assessment (RC operations) (-$4,500,000 General Fund):* Budget Act of 2002, trailer bill language was adopted to extend the amount of time allowed for the Regional Center's to conduct assessment of new consumers from 60 days to 120 days following the initial intake. The Governor proposes to continue this extension through 2007-08 through trailer bill language. This is the same language as used in previous years.

- *B. Calculation of Case Management Ratios (RC Operations) (-$32.8 million or -$16.2 million General Fund):* Through the Budget Act of 2003, trailer bill language was adopted to reduce the average RC case manager to consumer ratio from one to 66 (one Case Manager to 66 consumers). Previously, the ratio was one to 62. The Governor proposes to continue this extension through 2007-08 through trailer bill language. This is the same language as used in previous years.

- *C. Non-Community Placement Start-Up Suspension (-$6 million General Fund):* Under this proposal, a Regional Center may not expend any purchase of services funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the DDS has granted authorization for the expenditure. The Administration's proposed trailer bill language would continue this freeze through 2007-08. The Legislature did provide $3 million (General Fund) for this purpose in 2006-07.

- *D. Freeze on Rate Adjustments for Day Programs, In-Home Respite Agency and Work Activity Programs (-$3.9 million or -$2.9 million General Fund):* The rate freeze means that providers who have a temporary payment rate in effect on or after July 1, 2007 cannot obtain a higher permanent rate, unless the RC demonstrates that an exception is necessary to protect the consumers' health or safety. It should be noted that these programs did receive rate increases in the Budget Act of 2006. As such, their rates for 2007-08 would be frozen at these levels, unless otherwise adjusted as noted.

- *E. Freeze Service Level Changes for Residential Services (-$47.4 million or -$28.4 million General Fund).* This proposed trailer bill language would provide that RCs can only approve a change in service level to protect a consumer's health or safety and the DDS has granted written authorization for this to occur. This action maintains rates at the July 1, 2007 level.

- *F. Elimination of Pass Through to Community-Care Facilities (-$3.2 million, or $1.9 million General Fund):* The SSI/SSP cost-of-living-adjustment that is paid to Community Care Facilities by the federal government is being used to off-set General Fund expenditures for these services for savings of $3.2 million ($1.9 million General Fund).

- *G. Contract Services Rate Freeze (-$160.6 million or -$190.7 million General Fund):* Some RCs contract through direct negotiations with providers for certain services in lieu of the DDS setting an established rate. Continuation of the rate freeze would mean that RCs cannot provide a rate greater than that paid as of July 1, 2007, or the RC demonstrates that the approval is necessary to protect the consumer's health or safety. The Administration's proposed trailer bill language is the same as last year's, with a date extension to include 2007-08.

- *H. Habilitation Services Rate Freeze (-$2.2 million, or -$2.8 million General Fund):* The Habilitation Services Program consists of the (1) Work Activity Program (WAP), and (2) Supported Employment Program (SEP). The WAP services are primarily provided in a sheltered setting and are reimbursed on a per-consumer-day basis. SEP enables individuals to work in the community, in integrated settings with support services provided by community rehabilitation programs. The Administration's proposed trailer bill language would continue the rate freeze into 2007-08.

  I. Non-Community Placement Start-Up Suspension (-$6 million): Under this proposal, a Regional Center may not expend any Purchase of Services funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the DDS has granted authorization for the expenditure. The Administration's proposed trailer bill language would continue this freeze through 2007-08.

With respect to the startup of new programs, the Administration notes that funding would be provided to protect consumer's health and safety or to provide for other extraordinary circumstances as approved by the DDS.

Limits on this funding were first put into place in 2002. It should be noted that in the Budget Act of 2006, the Legislature did appropriate $3 million (General Fund) for these purposes.

Background—Regional Centers and the Purchase of Services. Among other things, Regional Centers (RCs) also purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities. **Generally, RCs pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called "generic" services that are provided at the local level by the state, counties, cities, school districts, and other agencies.** For example, Medi-Cal services and In-Home Supportive Services (IHSS) are "generic" services because the RC does not directly purchase these services.

Services and supports provided for individuals with developmental disabilities are coordinated through the Individualized Program Plan (IPP). The IPP is prepared jointly by an interdisciplinary team consisting of the consumer, parent/guardian/conservator, persons who have important roles in evaluating or assisting the consumer, and representatives from the Regional Center and/or state Developmental Center. Services included in the consumer's IPP are considered to be entitlements (court ruling).

In addition, as recognized in the Lanterman Act, differences (to certain degrees) may occur across communities (Regional Center catchment areas) to reflect the individual needs of the consumers, the diversity of the regions which are being served, the availability and types of services overall, access to "generic" services (i.e., services provided by other public agencies which are similar in charter to those provided through a Regional Center), and many other factors. This is intended to be reflected in the IPP process.

Subcommittee Staff Recommendation—Approve Funding and Trailer Bill Language for Cost Containment. It is recommended to approve the Administration's May Revision for the Regional Centers as proposed. The May Revision reflects minor adjustments primarily based on updated data. The continuation of the various cost containment adjustments is necessary at this time. Further, as noted in the April 9th hearing, programs did receive a three percent across-the-board increase in 2007-08, along with additional adjustments for employment programs.

It should be noted that all actions previously taken in the April 9th and May 7th hearings remain, including all fiscal and language adjustments taken regarding the closure of Agnews Developmental Center.

Questions. The Subcommittee has requested the DDS to respond to the following questions.

1. **DDS**, Please provide a *brief* summary of the key components of the May Revision, which have changed from January, for the Purchase of Services funding for the Regional Centers.

2. Update on the Agnews Developmental Center Closure—Community *&* DC

Prior Subcommittee Hearing. The Subcommittee discussed the Agnews Developmental Center closure in its April 9th and May 7th hearings. Actions taken by the Subcommittee in these hearings remain as enacted. These actions include the following:

- Increased by $503,000 ($126,000 General Fund) to support 4 new positions (three Chief Health Care Community Specialists and one Assistant Health Care Community Specialist) at the three Bay Area Regional Centers.
- Adopted trailer bill language to ensure the continuity of consumer's health care and accountability within the Administration, as well as at the community level between the Regional Centers and the health plans.
- Adopted trailer bill language for the DDS to continue operation of the Agnews Outpatient Clinic until DDS no longer has possession of the property.
- Directed the DDS to purchase two mobile clinics, using existing Wellness Funds, to be specifically outfitted to provide a range of health and medical services as determined by the DDS in working with constituency groups. Adopted language to enable the DDS to purchase the mobile clinics using a competitive process but is to be exempted from public contract code due to the need to ensure the protection of public health and welfare.
- Adopted placeholder trailer bill language to codify the Medi-Cal Program's verbal commitment regarding Medi-Cal reimbursement to the local health plans for Medi-Cal services provided for people transitioned from Agnews DC to the community.
- Adopted revised reporting language for the DDS to provide additional information regarding the Agnews DC closure to the Legislature.

Governor's May Revision. The **Governor's May Revision reflects minor adjustments related to the Administration's closure of the Agnews Developmental Center by June 30, 2008.** These adjustments are reflected in both the Regional Center item *and* Developmental Center item of the Budget Bill due to the transitioning of consumers from Agnews to other living arrangements.

Overall, the May Revision proposes a *net increase* to the developmental services system of $24.5 million ($17.7 million General Fund) due to the anticipated transition of consumers from the Agnews Developmental Center into the community, as compared to the revised 2006-07 budget. This net figure includes increases for the Regional Center budget of $35.2 million ($23.4 million) over the revised 2006-07 budget, and a decrease of $10.7 million ($5.7 million General Fund) for the Developmental Centers over the revised 2006-07 budget.

The proposed adjustments are consistent with the Administration's updated plan provided to the Legislature on May 14, 2007, as required by statute.

As of March 31, 20007, 244 residents remained at Agnews. To date, 115 residents have transitioned into the community since the closure planning process began in July 2004. It is estimated that a total of 70 consumers will transition from Agnews into the community in the current year. The DDS states that all residents are expected to move from Agnews by the time of its planned closure in June 2008.

As of March 31, 2007, there were 1,003 employees at Agnews. The attrition rate for the current fiscal year is consistent with last fiscal year's and is at about 15 percent. The DDS states that licensed personnel such as registered nurses and psychiatric technicians comprise a significant majority of the separations. There has also been an increase in the proportion of administrative and support staff who are separating.

The DDS further states that Agnews is maintaining sufficient staff to protect the health and safety of remaining residents and to ensure the ongoing certification of the facility.

Key changes and updates as contained in the May Revision are as follows:

- *Placements into the Community.* It is assumed that 188 residents are transitioned into the community in 2007-08 for total expenditures of $52.6 million (total funds) which reflects a net reduction of $3.1 million (total funds) due to a series of technical adjustments.
- *Agnews Developmental Center State Staff in the Community.* State statute provides for Agnews DC state staff to be deployed in the community for up to two years post-closure (up to 200 staff). The May Revision continues the January budget assumption that $9.2 million (total funds) for 47 positions are in the base estimate, but an increase of $242,000 ($129,000 General Fund) is provided for six positions to be added effective as of January 1, 2008. These positions are consistent with the overall closure plan for Agnews.
- *Bay Area Housing Project.* A total of 62 Bay Area Housing Project homes are planned for development as discussed in the April 9th hearing. All of these homes will be purchased by June 30, 2007.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the Administration's May Revision for the Agnews Developmental Center.

All other Subcommittee actions taken on April 9th and May 7th remain, as noted on the preceding page.

Questions. The Subcommittee has requested the DDS to respond to the following questions.

1. **DDS**, Please provide an update regarding the key components of the May Revision as they pertain to the Agnews Developmental Center closure.

Developmental Centers

1. Developmental Centers (Issues 100, 101, and 102)

Governor's May Revision The budget proposes total expenditures of $720.3 million ($391.5 million General Fund) to serve 2,610 residents who reside in the DC system.

This reflects a caseload increase of 21 residents and an increase of $2.1 million (a decrease of $89,000 General Fund and an increase of $2.2 million in Reimbursements from federal Medicaid funds) as compared to the January budget.

The *key* adjustments are as follows:

- *Staffing Adjustment.* A decrease of $1.1 million ($804,000 General Fund) is reflected based on the staffing requirements and operations of each Developmental Center (DC), including planned unit closures. The funding level reflects an increase of 27 Level-of-Care staffing and a decrease of 65.5 Non-Level-of-Care staffing. The net result is a reduction of 38.5 staff, even though there is an anticipated increase of 21 DC residents as compared with the January budget. This projected increase in the DC population is due to a slower than projected transfer of DC consumers into the community.

- Salary Enhancement for "Coleman". An increase of $286,000 ($167,000 General Fund) is proposed to fund salary increases for vacant mental health classifications including phased hiring of Psychiatrists, Psychologists, Social Workers, Psychiatric Technicians, Occupational and Rehabilitation Therapists, Medical Directors, Unit Supervisors, Senior Psychiatric Technicians, and Senior Psychologists. The DDS states that these increases are necessary to allow hiring and retention of these employees. It should be noted that the salary increases will continue to be phased-in as positions are filled in 2008-09

  The funding level assumes positions will be filled as follows: (1) 11.5 positions per month from July 2007 to December 2007; and (2) 16.5 positions per month from January 2008 to June 2008.

  These increases will bring salaries up to 18 percent less than the salaries in the CA Department of Corrections and Rehabilitation (CDCR) that were increased as a result of the "Coleman" order, with the exception of Psychiatrists and Senior Psychologists which will be brought to 5 percent less than CDCR salaries.

  Subcommittee staff notes that this request is consistent with the Department of Mental Health's request which is discussed in detail below.

- *Salary Enhancements for Dental Professionals (Perez).* An increase of $1.3 million ($747,000 General Fund) is proposed to increase salaries for authorized dental classifications. These increases would effect 11.5 Dentists and 12 Dental Assistants at the five Developmental Centers (23.5 total positions)

  The purpose of this increase is also to bring salaries for incumbents in these classifications to 18 percent less than the salaries for corresponding classifications in the CDCR.

- *Sonoma Developmental Center Asbury Creek Water Diversion*. An increase of $2 million (General Fund) on a one-time only basis is proposed for the construction phase of the Asbury Creek water diversion replacement project to replace the water diversion structure that was destroyed in the winter storms in December 2005.

  There are two water diversion structures at Sonoma DC due to the creeks. These two creeks are the main water sources for the two reservoirs on the Sonoma DC property. The reservoirs supply water year round to meet the daily needs of the Sonoma residents and employees. The Mill Creek diversion repairs were completed in November 2006 with redirected support funds from special repairs. Other critically needed special repair projects were deferred due to this emergency project.

  The DDS states that the Asbury Creek diversion replacement project is stalled in the working drawing phase due to the lack of funds. The May Revision funding is requested to complete the construction phase of this project before the rainy season to ensure an adequate water supply for the DC.

Subcommittee Staff Recommendation—Approve. The May Revision for the Developmental Centers reflects reasonable adjustments that are necessary in order to hire and retain employees, as well as to ensure DC resident health and safety. No issues have been raised.

Questions. The Subcommittee has requested the DDS to respond to the following questions.

1. **DDS**, Please provide a *brief* overview of the key components of the proposed May Revision for the Developmental Centers.

E. Item 4440 Department of Mental Health *(Discussion Items)*

Community-Based Mental Health & State Support Issues

1. Significant Issues Regarding the Early, Periodic Screening and Treatment (EPSDT) Program Requires Legislative Oversight and Funding (Issues 240, 241, 242, 243 & 244)

Prior Subcommittee Hearings. The Subcommittee has discussed the Department of Mental Health's (DMH) mismanagement of the EPSDT Program in its March 12th hearing and April 30th hearing. In the March 12th hearing, the Subcommittee directed the DMH to provide the Subcommittee with a work plan to begin to remedy the myriad of issues regarding this important program.

To recap, the myriad of issues with the DMH regarding this program included the following:

- A deficiency request of at least $302.7 million (General Fund) for past years owed to the County Mental Health Plans (County MHPs);
- An accounting error which represents a significant portion of what is owed to the County MHPs;
- Double billing of the federal government (i.e., Medicaid/Medi-Cal funds) by the state (DMH and Department of Health Care Services);
- A pending federal audit report which *could* have additional General Fund implications;
- A claims processing method (i.e., billing system) which is manually operated;
- Use of an inaccurate methodology for estimating program expenditures for budgeting purposes;
- Use of a "cost settlement" process for closing out costs for past fiscal years;
- A lack of timeliness and accountability on the part of the Administration in informing the Legislature and bringing forth these issues; and
- Need for the Office of State Audits and Evaluations (OSAE), located within the Department of Finance, to conduct analyses and make recommendations in several areas.

Through a new leadership team, the DMH has begun to more assertively address several of its issues regarding this program. These efforts included providing the Subcommittee with an initial EPSDT Program work plan. This work plan was discussed in the April 30th hearing.

In the April 30th hearing, the Subcommittee took the following actions: (1) Left *"open"* prior year, current year and budget year funding issues pending receipt of the Governor's May Revision**; (2)** adopted trailer bill language to require the DMH to provide the Legislature with specified work products on a flow-basis as contained in the DMH work plan presented at the hearing; and **(3)** adopted Budget Bill Language for the DMH to work collaboratively with the Legislature to develop an appropriate administrative structure for the EPSDT Program for implementation in 2008-2009, including the passage of legislation to establish the administrative structure. All of these language actions remain enacted.

Governor's May Revision—More General Fund Requested. The Governor's May Revision continues to propose several fiscal adjustments for prior years and the current year, and also proposes an increase above the January budget for 2007-08. **The following table provides a perspective on these proposed funding adjustments.**

Table 1: May Revision: Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Fiscal Issue/Component	Governor's January General Fund Increase	May Revision Total General Fund	General Fund Increase Above January
2003-04 Cost Settlement	$13.7 million	$13.7 million	--
2004-05 Unpaid Claims	$25.7 million	$25.7 million	--
2004-05 Cost Settlement	--	$17.2 million	$17.2 million
2005-06 Unpaid Claims	$203.6 million	$203.6 million	--
• **Total Prior Years**	**$243 million**	**$260.2 million**	--
• **2006-07 Deficiency**	**$59.7 million**	**$59.7 million**	**--**
• **2007-08 Baseline Increase**	**$92.7 million**	**$107.6 million (includes Jan & May)**	$14.9 million
TOTAL EPSDT Amount	**$395.4 million**	**$427.5 million**	**$32.1 million**

Each of the pieces shown in the above table are described below.

Prior Year $260.2 million. As noted above, the prior year deficiency of $260.2 million (General Fund) includes $243 million identified in January and another $17.2 million due to the May Revision and the cost settlement of 2004-05 (as noted in the table). Most of these prior year dollars were discussed in the March 12th hearing and their component pieces are listed below:

- $177 million for an accounting error that occurred for 2005-06 between the DMH and the Department of Health Services (i.e., an accrual accounting to cash accounting problem).
- $52.3 million due to the DMH using an out-dated fiscal methodology for projecting program expenditures which occurred for several past years. (This is presently being worked on to correct for future budgets and the Office of State Audits and Evaluations (OSAE) has been providing assistance to the DMH in this area.)
- $13.7 million for 2003-04 "cost settlement" process.
- $17.2 million for 2004-05 "cost settlement" process.

Current Year $59.7 million. The 2006-07 deficiency amount of $59.7 million (General Fund) remains the same in the May Revision. As discussed in the March 12th hearing, this increase is the amount the DMH believes it needs to balance this fiscal year once all of the claims are received and processed. The DMH states that the current year claims are being paid.

Budget Year $107.6 million. A total increase of $107.6 million (General Fund), or an increase of $14.9 million (General Fund) above the January budget, is requested for 2007-08. The DMH is proposing to eliminate their "cost settlement" process as recommended by OSAE. By eliminating the cost settlement process, the DMH intends to provide a more realistic forecast of program expenditures going into the budget year, versus a deficient funding approach which had been occurring.

The following table is a summary of state and federal expenditures for the EPSDT Program. County Mental Health Plans also provide a baseline amount, along with a 10 percent sharing level above the baseline. For 2007-08, county funds will contribute a total of $86.9 million towards the program. The county fund amount consists of $67.9 million for their baseline and $19 million for the added 10 percent above the baseline.

Table 2 Summary of EPSDT Program (Federal & State Funding) as Proposed by DMH

Fiscal Year	Federal Funds	General Fund Total	Total Funds
2005-06	$410.4 million	$400.5 million	$810.9 million
2006-07	$630.8 million	$649.2 million	$1.280 billion
2007-08	$485.5 million	$471.2 million	$956.7 million

Background--How the EPSDT Program Operates. Most children receive Medi-Cal services through the EPSDT Program. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. Examples of mental health services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

Though the DHS is the "single state agency" responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH). Further, County MHPs are responsible for the delivery of EPSDT mental health services to children

In 1990, a national study found that California ranked 50th among the states in identifying and treating severely mentally ill children. **Subsequently due to litigation (T.L. v Kim Belshe' 1994), the DHS was required to expand certain EPSDT services, including outpatient mental health services.** The 1994 court's conclusion was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated.

County MHPs must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a "baseline" amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on the counties through an administrative action in 2002.

Subcommittee Staff Recommendation—Modify the Request. The EPSDT Program is a valuable program which provides critical mental health treatment services to children. Unfortunately, through a series of missteps, the DMH has created a fiscal situation which needs to be remedied but cannot be completely addressed in one fiscal year.

Further, though a new leadership team is progressing well to address the many issues, there are still questions which are pending. These questions pertain to **(1)** potential federal audit exceptions; **(2)** pending full repayment of federal double billing; **(3)** verification of 2005-06 claims; **(4)** pending cost settlements for 2005-06 and 2006-07 which will likely not be known for at least one more year, and possibly two; **(5)** potentially other changes to the projection methodology, and **(6)** the overall management of the program.

Answers to these questions are not fully imminent and will still require considerable work on the part of the DMH and constituency groups.

It is therefore recommended to do the following:

- Technically adjust reimbursements received from the Department of Health Care Services to correspond to the following General Fund appropriations (federal Medicaid matching funds are provided by the DHCS) to be taken.
- Approve a total increase of $59.7 million (General Fund) to fund the 2006-07 deficiency;
- Approve a total increase of $107.6 million (General Fund) to fund 2007-08;
- Establish a reimbursement through the mandate process by creating a new item as shown below, and provide for a three-year reimbursement process of the $260.2 million (General Fund) in prior year claims. The proposed mechanism for this is as follows:

  "Item 4440-295-0001. For local assistance, Department of Mental Health, for reimbursement of the costs for the Early Periodic Screening, Diagnosis and Treatment Program for prior years which total $260.2 million and will be reimbursed over a three year period, commencing with the Budget Act of 2007, for disbursement by the State Controller as validated by the Department of Mental Health……$86.7 million"

This will provide a total of $254 million (General Fund), or 59 percent, of the total $427.5 million (General Fund) amount.

Questions. The Subcommittee has requested the DMH to respond to the following questions:

1. **DMH,** Please provide a *brief* description of the EPSDT May Revision.
2. **DMH**, Please provide an update on the status of discussion with the federal government regarding the DMH's double billing and the federal audit and follow up.

2. Mental Health Managed Care Program—Two Issues

Prior Subcommittee Hearing. In the March 12th hearing, the Subcommittee approved technical adjustments as proposed for the program *and* placed $12 million (General Fund) on the Subcommittee's checklist to restore a 5 percent rate reduction to the program which had occurred as of July 1, 2003.

Specifically, Assembly Bill 1762, Statutes of 2003, reduced by 5 percent health care plans participating in the Medi-Cal Managed Care Program as administered by the Department of Health Care Services (DHCS), *and* also Mental Health Managed Care as administered by the DMH. The 5 percent rate reduction was applicable from July 1, 2003 through January 1, 2007.

Funding was restored for the health care plans within the DHCS Medi-Cal Program effective as of January 1, 2007, but the DMH has chosen not to provide the rate restoration (for the current year or the budget year). No rationale has been provided by the Administration as to why funding was not provided by the Governor in January to reflect the statutory sunset.

Governor's May Revision. The DMH proposes a reduction of $1.852 million ($926,000 General Fund) in local assistance for the Mental Health Managed Care Program. The DMH states that this adjustment is due to reduced caseload within the Medi-Cal Program as determined by the Department of Health Care Services.

It should be noted that the medical care price index adjustment (medical CPI), as contained in the enabling legislation for this program, was *not* funded by the Administration. An increase of about $9.5 million (General Fund) would be needed to provide for this adjustment. The last time a medical CPI was provided was in the Budget Act of 2000, or 7 years ago.

In addition, the Administration did *not* restore the 5 percent rate reduction which sunset as of January 1, 2007. This issue was placed on the Subcommittee's checklist in the March 12th hearing.

Background—How Mental Health Managed Care is Funded: Under this model, County Mental Health Plans (County MHPs) generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose.

An annual state General Fund allocation is also provided to the County MHP's. The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have included changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items. The state's allocation is contingent upon appropriation through the annual Budget Act.

Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 47 percent match while the state provided a 53 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

Background—Overview of Mental Health Managed Care: Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, are the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government. Medi-Cal recipients *must* obtain their mental health services through the County MHP.

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements.

Constituent Concerns on Need for 5 Percent Rate Restoration. The Subcommittee is in receipt of a letter from the CA Mental Health Directors Association (CMHDA) and the CA State Association of Counties (CSAC) who are seeking funding for the 5 percent rate restoration. They contend that without this restoration, coupled with the continued lack of a medical CPI, their ability to provide services to their target population of seriously mentally ill indigent individuals will continue to erode, with more County Realignment revenues going to provide the match for Medi-Cal services.

In addition to the prior year's rate reduction, they note that the medical CPI has not been funded by the state since the Budget Act of 2000. Since this time, medical inflation increases have occurred and the costs for providing Psychiatric services and prescription drugs continue to grow.

Further, CMHDA and CSAC note that although the Mental Health Services Act (i.e., Proposition 63) provided new revenues for mental health services, revenues from this act cannot be used to supplant existing programs.

Subcommittee Staff Recommendation—Approve May Revision with 5 Percent Rate Restoration. Mental Health Managed Care services are a core component to the public mental health system and it is important for the state to be a viable partner in the provision of resources provided towards this effort. The enabling statute for the 5 percent rate reduction had a sunset date that is applicable to all managed care plans. Consistency in the application of the rate restoration is only fair and equitable. Where is the parity for mental health services?

As such, it is recommended to: **(1)** approve the technical caseload adjustments as proposed by the Administration; **(2)** increase by $12 million (General Fund) for the 5 percent rate restoration; and **(3)** adopt corresponding trailer bill language for the rate restoration.

Questions. The Subcommittee has requested the DMH to respond to the following question.

1. **DMH,** Please provide a brief summary of the key May Revision adjustments, and why the DMH did *not* restore the 5 percent rate?

3. Forensic Conditional Release Program (CONREP) (Issues 230 & 231)

Governor's May Revision. The May Revision is requesting **a total increase of $929,000 (General Fund)** for the Forensic Conditional Release Program (CONREP) for total expenditures of $24.4 million (General Fund) in 2007-08. This total funding level supports a caseload of about 740 patients and the May Revision assumes at least 30 additional patients will be added to CONREP in 2007-08. Expenditures are for outpatient treatment services, ancillary services, supervision, State Hospital liaison visits, transitional residential facility contracts, and non-caseload services. The CONREP Program is budgeted under the DMH's state support item because it is a contract.

There are two components to the proposed $929,000 (General Fund) increase. **First**, an increase of $179,000 is for the hospital liaison visits. According to the DMH, the two primary population groups visited by CONREP providers are Not Guilty by Reason of Insanity (NGI) patients and Mentally Disordered Offenders (MDOs). Based on the most recent State Hospital patient population for these two classifications, it is estimated that about 2,682 patients will require two visits annually (i.e., 5,364 total visits for 2007-08, or 784 more than in 2006-07). On average, it costs $228 per visit. Therefore, an increase of $179,000 to fund 784 additional visits is needed. CONREP providers work with patients that State Hospital treatment teams identify as making good progress towards (or have achieved) their individual goals as stated in their individual "wellness and recovery" plan, and are outpatient-ready.

Second, an increase of $750,000 (General Fund) is requested to fund an increased enrollment of 30 patients. This funding level assumes an average per patient cost of $25,000 annually. The DMH states that increasing CONREP's capacity would increase discharges from State Hospitals and would help alleviate overcrowding throughout the State Hospital system.

Background—CONREP. This program provides for **(1)** outpatient services to patients into the Conditional Release Program (CONREP) via either a court order or as a condition of parole, and **(2)** hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually enter CONREP. **The patient population includes:** (1) Not Guilty by Reason of Insanity, (2) Mentally Disordered Offenders, (3) Mentally Disordered Sex Offenders, and (4) Sexually Violent Predators.

The DMH contracts with counties and private organizations to provide these mandated services in the state, although patients remain DMH's responsibility per statute when they are court-ordered into CONREP community treatment and supervision. The program as developed by the DMH includes sex offender treatment, dynamic risk assessments, and certain screening and diagnostic tools. Supervision and monitoring tools include Global Positioning System (GPS), polygraphs, substance abuse screening, and collaboration with law enforcement.

Subcommittee Staff Recommendation—Approve. No issues have been raised regarding the Administration's proposal. It is recommended for approval.

Questions. The Subcommittee has requested the DMH to respond to the following question.

1. **DMH,** Please provide a *brief* description of CONREP and the May Revision request.

4. Sexually Violent Predator (SVP) Evaluations and Court Testimony (Issues 220 & 221)

Prior Subcommittee Hearing. The March 12th Subcommittee hearing discussed the Administration's January proposal and the LAO's recommendation to reduce it. No action was taken since it was known that more information would be forthcoming at the May Revision because more data would be available regarding the effect of recent legislation and the passage of Proposition 83.

Governor's May Revision. The May Revision proposes an overall *net reduction* of $2.9 million (General Fund) from the January budget. This adjustment pertains to two issues. In addition, a reduction of $527,000 (General Fund) is proposed for the current year related to unfilled positions that will no longer be necessary.

First, this net reduction reflects a revision in the estimate methodology to determine the number of Sexually Violent Predator (SVP) evaluations to be performed by private contractors and the costs for evaluator court testimony. These various changes are noted in the Table below.

Table: Summary of Evaluation Components and Funding per the Administration

Evaluation Component	Governor's January Proposal 2007-08 (GF)	Governor's May Revision 2007-08 (GF)	Difference
Initial Evaluations ($3,835 per service)	$17.8 million (total of 4,644 services)	$19.9 million (total of 5,197 services)	$2.1 million
Initial Court Testimony ($3,660 per service)	$5.4 million (total of 1,486 services)	$732,000 (total of 200 services)	-$4.7 million
Evaluation Updates ($2,846 per service)	$2.3 million (total of 743 services)	$410,000 (total of 144 services)	-$1.9 million
Recommitment Evaluations ($4,422 per service)	$533,000 (total of 159 services)	$1.6 million (total of 356 services)	$1.041 million
Recommitment Court Testimony ($3,828 per service)	$1.133 million (total of 296 services)	$1.087 million (total of 284 services)	-$47,000
Recommitment Updates ($2,844 per service)	$1.6 million (total of 578 services)	$853,000 (total of 300 services)	-$790,000
Evaluator Training (ongoing) ($1,721 per service)	$69,000 (total of 40 services)	$138,000 (total of 80 services)	$69,000
Evaluator Training (one-time) ($7,200 per service)	---	$144,000 (total of 20 services)	$144,000
Airfare Costs	$1.1 million	$995,000	-$163,000
Consulting Services	$290,000	$1.5 million	$1.2 million
Information Technology (one-time costs)	---	$111,000	$111,000
Totals (rounded)	**$30.4 million**	**$27.4 million**	**-$2.9 million**

As noted in the table above, the DMH anticipates that initial evaluations will increase as more referrals are made by the CA Department of Corrections and Rehabilitation (CDCR). However, expenditures for initial court testimony and evaluation updates are proposed for reduction based on recent data on the monthly average of actual services performed.

The DMH projects an increase in recommitment evaluations because the courts have allowed SVPs who are currently under a two-year term to have a recommitment trial to determine if SVP criteria is met and if so, sentenced the SVP to an indeterminate term.

The DMH is also proposing an increase in consulting services of $1.2 million as compared to January. The DMH states that it is more efficient to engage contract clinicians at the front end of the SVP process and have them screen all cases referred by the CDCR. They contend that although this change in the process has increased costs for initial screenings the overall percentage of SVP cases referred on for full evaluation (i.e., two initial evaluations as required by law) has dropped from 42 percent to 31 percent. Contracted evaluators conducting the initial screenings are reimbursed at a rate of $200 per hour and it takes an average of one hour to screen each case (i.e., 7,620 cases at $200 for $1.5 million total costs).

Second, the revised amount includes a one-time only funding request of $111,000 to support information technology resources which the DMH states is needed for the SVP evaluation process. Specifically, the DMH is proposing the consolidation of certain data sources through this project which is intended to better manage case files and associated notes, memos and legal documents.

Background—CA Department of Corrections & Rehabilitation (CDCR) Referral to the DMH. Specified sex offenders who are completing their prison sentences are referred by the CDCR and the Board of Parole Hearings to the DMH for screening and evaluation to determine whether they meet the criteria as SVP.

When the DMH receives a referral from the CDCR, the DMH does the following:

- *Screening*. The DMH screens referred cases to determine whether they meet legal criteria pertaining to SVPs to warrant clinical evaluation. Based on record reviews, about 42 percent are referred for evaluation. Those not referred for an evaluation remain with the CDCR until their parole date.

- *Evaluations.* Two evaluators (Psychiatrists and/or Psychologists), who are under contract with the DMH, are assigned to evaluate each sex offender while they are still held in state prison. Based on a review of the sex offender records, and an interview with the inmate, the evaluators submit reports to the DMH on whether or not the inmate meets the criteria for an SVP. If two evaluators have a difference of opinion, two additional evaluators are assigned to evaluate the inmate.

Offenders, who are found to meet the criteria for an SVP, as specified in law, are referred to District Attorneys (DAs). The DAs, then determine whether to pursue their

commitment by the courts to treatment in a State Hospital as an SVP.

If a petition for a commitment is filed, the clinical evaluators are called as witnesses at court hearings. Cases that have a petition filed, but that do *not* go to trial in a timely fashion may require updates of the original evaluations at the DA's request.

The amount of time it takes to complete the commitment process may vary from several weeks to more than a year depending on the availability of a court venue and the DA's scheduling of cases. While these court proceedings are pending, offenders who have not completed their prison sentences continue to be held in prison. *However*, if an offender's prison sentence has been completed, he or she may be held either in county custody or in a State Hospital.

Background—SB 1128 (Alquist), Statutes of 2006. This legislation made changes in law to generally increase criminal penalties for sex offences and strengthen state oversight of sex offenders. For example, it requires that SVPs be committed by the court to a State Hospital for an undetermined period of time rather than the renewable two-year commitment provided under previous law.

This law also mandates that every person required to register as a sex offender be subject to assessment using the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO) a tool for predicting the risk of sex offender recidivism.

Background—Proposition 83 of November 2006—"Jessica's Law". Approved in November 2006, this proposition increases penalties for violent and habitual sex offenders and expands the definition of an SVP. The measure generally makes more sex offenders eligible for an SVP commitment by **(1)** reducing from two to one the number of prior victims of sexually violent offenses that qualify an offender for an SVP commitment, and **(2)** making additional prior offenses "countable" for purposes of an SVP commitment.

Subcommittee Staff Recommendation--Approve. The May Revision reflects a more realistic analysis of the anticipated expenditures for the budget year and it addresses the Legislative Analyst's Office's prior concerns with the January budget which over estimated expenditures. It is therefore recommended to adopt the May Revision. No issues have been raised.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. **DMH**, Please provide a *brief* explanation of the *key* May Revision changes using the table provided in the agenda.

Mental Health State Hospital Issues

Overall Background and Funding Sources. The department directly administers the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga. In addition, the DMH administers acute psychiatric programs at the California Medical Facility in Vacaville, and the Salinas Valley State Prison.

Patients admitted to the State Hospitals are generally either (1) civilly committed, or (2) judicially committed. As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans (County MHPs) contract with the state to purchase State Hospital beds. County MHPs reimburse the state for these beds using County Realignment Funds (Mental Health Subaccount).

Judicially committed patients are treated solely using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated through the Department of Mental Health (DMH).

Background—Overall Classifications of Penal Code Patients. Penal Code-related patients include individuals who are classified as: **(1)** not guilty by reason of insanity (NGI), **(2)** incompetent to stand trial (IST), **(3)** mentally disordered offenders(MDO), **(4)** sexually violent predators (SVP), and **(5)** other miscellaneous categories as noted.

The DMH uses a protocol for establishing priorities for penal code placements. This priority is used because there are not enough secure beds at the State Hospitals to accommodate all patients. This is a complex issue and clearly crosses over to the correctional system administered by the CA Department of Corrections and Rehabilitation (CDCR). The DMH protocol is as follows:

1. Sexually Violent Predators have the utmost priority due to the considerable public safety threat they pose.
2. Mentally Disordered Offenders have the next priority. These patients are former CDCR inmates who have completed their sentence but have been determined to be too violent to parole directly into the community without mental health treatment.
3. *Coleman v. Schwarzenegger* patients must be accepted by the DMH for treatment as required by the federal court. *Generally* under this arrangement, the DMH must have State Hospital beds available for these CDCR patients as required by the Special Master, J. Michael Keating Jr. If a DMH bed is not available, the inmate remains with the CDCR and receives treatment by the CDCR.
4. Not Guilty by Reason of Insanity is the next priority.
5. Incompetent to Stand Trial is the last priority. It should be noted that there are about 250 to 300 individuals who are incompetent to stand trial who are presently residing in County jails due to the shortage of beds within the State Hospital system.

Summary of Projected Patient Population—May Revision. The proposed May Revision patient caseload for each State Hospital is shown on the chart below. Each State Hospital is unique, contingent upon its original design, proximity to population centers, types of patients being treated at the facility and types of treatment programs that are available at the facility. **As noted below, there are *substantial* changes in the current year as well as budget year at both Atascadero and Coalinga. This will be discussed below.**

Table: DMH Summary of Population by Hospital *(DMH May Revision Estimate)*

Hospital Summary	Revised 2006-07 Caseload Adjustment	Revised 2006-07 Caseload	January 2007-08 Caseload Adjustment	May Revision 2007-08 Caseload Adjustment	May Revision 2007-08 Caseload
Atascadero	-153	1,208	7	121	1,336
Coalinga	-289	633	440	-176	897
Metropolitan	-20	647	21	68	736
Napa	0	1,195	0	0	1,195
Patton	-25	1,500	0	25	1,525
Vacaville	0	270	0	0	270
Salinas	0	136	0	0	136
TOTALS	**-487**	**5,589**	**468**	**38**	**6,095**

Overall Budget for the State Hospital System—May Revision. The May Revision proposes total expenditures of **$1.117 billion** ($1.039 billion General Fund) for 2007-08 to operate the five State Hospitals which will serve a revised total population of 6,095 patients, including patients located at Vacaville and Salinas Valley (CDCR contracts with DMH to administer the psychiatric units at these two facilities).

The May Revision reflects a current-year reduction of $25.511 million in General Fund support to reflect a reduction of 487 patients (or 531.8 state positions at half-year). This current year adjustment is then reflected in the budget year. This is discussed under issue 1, below.

The individual May Revision issues for the State Hospitals are discussed below.

1. May Revision Reflects Substantial Patient Population Changes Due to Staffing (Issues 200, 130, & 201)

Governor's May Revision. The May Revision reflects several substantial adjustments related to the State Hospital patient population. These patient population changes by category of patient are reflected in the Table below. The fiscal implications of these changes are discussed individually.

First, the May Revision reflects a *current-year* reduction of $25.1 million in General Fund support to reflect a reduction of 487 patients (or 265 state positions at half-year). **This current year adjustment is then reflected in the budget year for a reduction of $28.2 million (General Fund) and 531.8 positions to reflect full-year impact.**

The DMH states that a substantial part of this patient population decline is attributable to the *Coleman* salary increase that was given to the California Department of Corrections and Rehabilitation (CDCR). Many of DMH's clinical staff left the State Hospitals for employment with the CDCR for the salary increase. This exodus of clinical staff put the DMH in the position of having to reduce admission to the State Hospitals, specifically at Atascadero and Napa State Hospitals.

As discussed in Issue 2 below, the Administration commenced with *Coleman* related salary increases beginning April 1, 2007. The Administration notes that the *Coleman* related salary increases will bring DMH State Hospital employees to within 5 percent and 18 percent of total parity with the same classifications as the CDCR. The DMH believes that many staff that left for the salary increase at the CDCR will be returning to the State Hospitals as a result of the DMH providing a salary adjustment in the current year. Because of this, the DMH expects to increase admissions by 100 patients for the last quarter (April 1, 2007 to June 30, 2007) of the current year.

Table: Summary of State Hospital Patient Population by Caseload Type

Caseload Type	Revised 2006-07 Caseload Adjustment	Revised 2006-07 Caseload	January 2007-08 Caseload Adjustment	May Revision 2007-08 Caseload Adjustment	May Revision 2007-08 Caseload
Incomp Stand Trial	-71	1,058	-38	158	1,178
Not Guilty Insanity	-68	1,246	-9	46	1,283
Mentally Disordered Offender	-106	1,218	53	54	1,325
SVP	-242	647	440	-220 over estimated	867
Other Penal Code	0	118	0	0	118
PC 2684s & 2974s	0	752	0	0	752
CA Youth Authority	0	30	0	0	30
Civil Commitments	0	520	22	0	542
TOTALS	**-487**	**5,589**	**468**	**38**	**6,095**

Second, the DMH is reflecting a savings of $21.7 million (General Fund) to reflect an estimated 50 percent reduction in the number of Sexually Violent Predator (SVP) commitments to the State Hospitals as compared to the Governor's January budget. As discussed in the March 12th Subcommittee hearing, the DMH January methodology assumed that 8 percent of the SVP referrals from the CDCR would result in a commitment to the State Hospital. As noted by the Legislative Analyst's Office (LAO), this methodology was flawed. The DMH is now assuming a 4 percent level for commitments. As such, a 50 percent reduction is proposed.

Third, the DMH is proposing an increase of $4.4 million (General Fund) to reflect a *net* increase in the judicially committed penal code patient population of 38 patients, including an increase of 158 Incompetent to Stand Trial (IST), 46 Not Guilty by Reason of Insanity (NGI), 54 Mentally Disordered Offenders (MDOs), and a decrease of 220 Sexually Violent Predators (SVP). The DMH states that the net increases are projected based on an anticipated increase in staffing from the Coleman salary increases, effective as of April 1, 2007.

Subcommittee Staff Recommendation--Approve. It is recommended to adopt the May Revision population adjustments for the State Hospitals. As noted, a portion of the adjustments is due to the recalculation of assumptions regarding the potential affects of recent law changes regarding the SVP population. The remaining adjustments reflect the need to recruit and retain staff in order to provide patient services, as well as adjustments to reflect the priority placement of patients. No issues have been raised.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. **DMH,** Please provide a *brief* summary of the key May Revision changes.

2. Coleman Lawsuit –Related Salary Adjustments (Issues 120, 202 & 204)

Governor's May Revision. The Administration is proposing **three adjustments** to the salaries paid to certain State Hospital classifications that are in *Coleman-related* classifications. It should be noted that the Administration authorized the DMH to begin current-year salary increases effective as of April 1, 2007, using existing funds which were available due to the high level of vacant positions (as noted in issue 1, above).

It should be noted that the Subcommittee discussed concerns regarding the high level of vacant positions and concerns with patients receiving active treatment in the March 12th hearing, *prior* to any action on the part of the Administration.

The three budget year adjustments as contained in the May Revision are as follows:

- *Funding of "Filled" Positions.* An increase of $29.5 million (General Fund) is proposed to bring salaries for "filled" professional and Level-of-Care mental health classifications closer to parity with the CDCR salaries which were increased as the result of the *Coleman* court.

  This proposed level of funding would bring DMH salaries for incumbent staff in the following Coleman-related positions to *5 percent less than CDCR salaries*: Staff Psychiatrist (safety); Senior Psychiatrist (specialist); Senior Psychiatrist (supervisor); Medical Director (state hospital); Senior Psychologist (HF supervisor); Senior Psychologist (CF supervisor).

  In addition, it would bring other DMH salaries for incumbent staff in the following Coleman-related positions to *18 percent less* than CDCR salaries: Psychiatric Technician (safety); Senior Psychiatric Technician (safety); Unit Supervisor (safety); Psychologist (HF); Chief Psychologist; Rehabilitation Therapist (recreation and safety); Rehabilitation Therapist (music and safety); Rehabilitation Therapist (occupational and safety); Rehabilitation Therapist (art and safety); Rehabilitation Therapist (dance and safety); Clinical Social Worker (H/CF and safety); Supervising Psychiatric Social Worker I.

  This funding increase will raise salaries for Psychiatrists and Senior Psychologists by between 66 percent and 74 percent, and raise salaries for other impacted mental health classifications by between 10 percent and 40 percent.

- *Funding of "Vacant" Positions.* An increase of about $6 million (General Fund) is proposed to provide funding for DMH classifications as noted above for vacant positions and those related to patient population growth. This level of funding assumes a phased-in approach rather than full-year funding to account for positions as they are hired throughout the fiscal year.

  The DMH has provided the following chart, below, as it pertains to their Coleman staffing plan for 2007-08. The DMH states that there are 1,860 total vacant positions (as of May Revision) and that the average cost per month to fill them is $1,348, with a full year cost of $30.1 million (which would be in 2008-09).

Table: DMH Hiring Perspective for the Budget Year

Month in 2007-08	Number of Staff Phased-In Per Month	Cost Per Month
July	50	$808,529
August	50	$741,151
September	50	$673,774
October	50	$606,396
November	50	$539,109
December	50 (300 staff total at mid-point)	$471,642
January 2008	75	$606,396
February	75	$505,330
March	75	$404,264
April	75	$303,198
May	75	$202,132
June	75	$101,066
Total (Rounded)	**750 staff**	**$6.0 million**

The Administration is also proposing Budget Bill Language to authorize increased funding above the pending Budget Act of 2007 for salaries if more vacancies than anticipated are filled, or if funding is needed for contract costs for registry funding. **The *Administration's* proposed Budget Bill Language is as follows (Item 4440-011-0001):**

> "Notwithstanding any other provision of law, the Department of Finance may augment this item to provide salary increases for classifications related to the Coleman litigation in the event that more vacant positions are filled than were originally proposed in the 2007-08 staffing plan, or for contract costs for registry funding, if necessary. This item may not be augmented sooner than 30 days after notification in writing of the necessity therefore to the chairperson of the committee of each house of the Legislature that considers appropriations and the Chairperson of the Joint Legislative Budget Committee, or whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine."

- *Technical Adjustment for Vacaville and Salinas Valley Psychiatric Programs.* The DMH is also proposing a reduction of $336,000 (General Fund) to reflect a technical correction for an employee compensation adjustment to the budget for Coleman salary increases that were provided to employees in these two facilities in the January budget. These two programs had received increases because they are within CDCR-operated facilities.

Background—Coleman vs. Schwarzenegger and CDCR Salaries. The Special Master assigned to the *Coleman vs. Schwarzenegger* (Coleman) recommended, and the federal court has ordered, significant salary increases for a number of health care classifications within the CA Department of Corrections and Rehabilitation (CDCR) to address the severe shortage of mental health care employees within the CDCR institutions. By order of the court, CDCR salary increases were implemented as of March 31, 2007 and are retroactive to January 1, 2007.

It is crucial that Coleman-related classifications in all DMH facilities receive financial incentives that bring salaries closer to parity with CDCR salaries, in order to prevent more State Hospital staff from transferring to CDCR facilities.

Subcommittee Staff Recommendation—Adopt Fiscal Adjustments with Modified Budget Bill Language. It is recommended to approve the three fiscal adjustments as proposed, but to adopt modified Budget Bill Language. **In *addition* to the Administration's proposed Budget Bill Language**, **it is recommended to *add* the following language as part of the overall proposal:**

> "The Department of Mental Health shall provide the fiscal and policy committees of the Legislature, including the Chairperson of the Joint Legislative Budget Committee, and the Department of Finance with a quarterly update on the progress of the hiring plan to ensure appropriate active treatment for patients, state licensure requirements, and in meeting the Consent Judgment with the federal United States Department of Justice regarding the federal Civil Rights of Institutionalized Persons Act (CRIPA)." This quarterly update shall be provided within 10 working days of the close of the quarter to ensure the exchange of timely and relevant information.

Questions. The Subcommittee has requested the DMH to respond to the following question.

1. **DMH,** Please provide a brief summary of the May Revision request, including the Budget Bill Language and how it would work.

3. Salary Adjustment for the Perez (Issue 203)

Governor's May Revision. The DMH is requesting an increase of $1.592 million ($1.560 million General Fund) to raise salaries for all budgeted DMH dental staff to 18 percent less than the CDCR salaries resulting from this case. This funding will increase salaries for these positions by between 36 percent and 58 percent. The DMH states that this funding is necessary to properly protect and serve the DMH clients by retaining existing staff and enhancing the recruitment of additional dental professionals.

Subcommittee Staff Recommendation—Approve May Revision. It is recommended to approve the May Revision.

Questions. The Subcommittee has requested the DMH to respond to the following question.

1. **DMH**, Please provide a *brief* explanation of the May Revision.

4. Salinas Valley Psychiatric Program—18 Bed Unit for IST's (Issue 207)

Governor's May Revision. The May Revision requests an increase of $696,000 (General Fund) for the DMH to support four Level-of-Care staff to operate an 18-bed unit at Salinas Valley Psychiatric Program (Salinas) for Incompetent to Stand Trial (ISTs) patients who are too dangerous to reside within the State Hospital setting.

The DMH is required by statute to provide services for inmates that have been adjudicated pursuant to Penal Code 1370—Incompetent to Stand Trial (IST). The DMH notes that there has been an increase in the number of individuals who meet the PC 1370 criteria and are too dangerous to reside within the State Hospitals. Therefore, Salinas has started to admit these individuals and requires additional staff to meet the trial competency training requirements listed under PC 1370.

Specifically, the DMH states there are 32 ISTs on the waiting list for Salinas with the list growing at 3 per month. To accommodate this growing need, Salinas will be dedicating 18 beds out of the existing 100 beds designated for *Coleman* to use exclusively for the IST population. In order to comply with *Coleman*, this 18-bed unit must be staffed by those trained to fulfill stringent competency requirements. Therefore, due to these competency requirements, shifting staff from other existing units will not suffice.

At this time, Salinas has no Level-of-Care staff dedicated to performing the competency restoration process for the 18-bed IST unit. Therefore, the May Revision is proposing the following four positions, all of whom are specially trained: a Staff Psychiatrist; a Psychologist; a Clinical Social Worker; and a Recreation Therapist.

Background—the DMH's Involvement with Salinas Valley and *Coleman.* The DMH has an interagency agreement to provide mental health services for the CA Department of Corrections and Rehabilitation (CDCR) inmates per the *Coleman* federal court case naming CDCR as defendants. The DMH provides these mental health beds primarily at Atascadero State Hospital, Coalinga State Hospital, the Vacaville Psychiatric Program and the Salinas Valley Psychiatric Program within the prison.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the May Revision.

Questions. The Subcommittee has requested the DMH to respond to the following question.

1. **DMH**, Please provide a *brief* summary of the proposal.

5. Pilot Treatment Project for IST Patients (Issue 205)

Governor's May Revision. The May Revision proposes an increase of $4.3 million (General Fund) to pilot a treatment option through contracts with providers for treatment of services for those Incompetent to Stand Trial (IST) individuals ***not*** currently residing in State Hospitals (but may be on a waiting list), thereby reducing the State Hospital IST patient population through natural attrition and creating additional bed capacity for other forensically committed individuals.

The DMH notes that their inability to admit ISTs to the State Hospitals as needed, essentially due to the growth of the forensic population coupled with the increased vacancy rates in health care related classifications (as discussed above relating to the "Coleman" salary issues), have a significant impact on county jails.

The DMH proposal requests to establish, via contracts with providers, inpatient and outpatient restoration of competency programs (ones that can stand ready to receive referrals from Superior Courts across the state). These programs would be responsible for intensive psychiatric treatment, acute stabilization services, and court-mandated services for patients needing competency evaluations, insanity evaluations and restoration to trial competency.

The DMH request for $4.3 million (General Fund) is an estimate that is based upon costs reviewed from existing programs (CONREP is $25,000 per bed and only provides basic services, while a higher bed rate of $60,000 also includes room and board, medications, and competency training and other services in a locked facility).

The DMH states that this pilot approach would begin to address issues which can prevent the timely treatment of individuals who need restoration of competency to stand trial and can help provide a tool to better manage the State Hospital population, as well as try to balance county needs.

Background—IST Population and Demands on State Hospital Beds. As noted previously, the DMH uses a protocol for establishing priorities for Penal Code placements in the State Hospitals because there are not enough secure beds a the State Hospitals to accommodate all patients. Individuals who are deemed to be IST are the last priority.

At any point in time during the past year, there have been as many as 300 individuals in California jails awaiting admission to state psychiatric hospitals for restoration of competency so that they can proceed with their criminal trials. The DMH notes that the impacted State Hospital system prevents the timely and appropriate transfer of these individuals to state psychiatric facilities for forensic evaluation, treatment and restoration of competency to stand trial.

Courts have issued orders to the DMH to show cause for IST individuals who await transfer from county jails to State Hospitals. Careful population management at the State Hospitals has thus far pre-empted any of these orders from progressing to contempt orders. The DMH contends that without proactive intervention, this will likely expose the state to more court orders, contempt citations, and ultimately lawsuits.

It should be noted that Section 1370 of the Welfare and Institutions Code (IST statute) allows for placement of the IST in other than a State Hospital. Specifically, the IST individual can be delivered by the sheriff … "for care and treatment to a public or private treatment facility approved by the Community Program Director that will promote the defendant's speedy restoration to mental competence or placed on out-patient status…" Therefore, the DMH can contract for the services of privately owned and operated secured treatment facilities or county facilities.

Legislative Analyst's Office Recommendation. The LAO recommends approving the $4.3 million (General Fund) May Revision proposal and to adopt the following Budget Bill Language to track the pilot's expenditures and to provide oversight for the Legislature. The language is as follows:

> 4440-011-0001.
>
> "x. Of the amount appropriated in this item, $4,280,000 is available only to provide appropriate treatment to individuals found incompetent to stand trial and who have not been committed to a state hospital. These funds may be encumbered not sooner than 30 days after the Department of Finance provides a written expenditure plan for these funds to the chairpersons of the fiscal committees in each house of the Legislature, and to the Chairperson of the Joint Legislative Budget Committee, or not sooner than any lesser time period determined by the Chairperson of the Joint Legislative Budget Committee, or his or her designee."

Subcommittee Staff Recommendation—Approve LAO Recommendation. It is recommended to approve the LAO recommendation. The pilot has merit and the DMH should be commended for beginning to address this difficult issue.

Questions. The Subcommittee has requested the DMH to respond to the following question.

1. **DMH**, Please provide a *brief* summary of the proposal and why it is recommended.

E. Item 0530 CA Health & Human Services Agency (CHHS)

1. Continued Concerns Regarding Management of Low-Level Radioactive Waste

Issue. Significant concerns regarding the Department of Health Services' (and soon the Department of Public Health) implementation of radiation control law has been the subject of legislative oversight hearings, investigations and litigation in both the state and federal courts.

Recent specific examples of these concerns include the following.

- Senator Romero and Senator Kuehl have submitted a request to the Joint Legislative Audit Committee (April, 2007) for a comprehensive audit and investigation to be conducted of the role of the Radiological Health Branch of the Department of Health Services (DHS) and the Southwestern Low-Level Radioactive Waste Commission in approving the export and disposal of thousands of tons of California Low-Level Radioactive Waste (LLRW) in Tennessee municipal landfills. It appears that the DHS and Southwestern LLRW Commission may be engaged in an unauthorized de facto deregulation of the handling and disposal of LLRW.
- Senate Bill 1970 (Romero), 2002, as passed by the Legislature, would have banned radioactive materials being placed in a landfill. Governor Davis vetoed the bill but issued Executive Order D-62-02, placing a temporary moratorium on landfilling radioactive waste, and directing the Department of Health Services to "adopt regulations establishing does standards for the decommissioning of radioactive materials by its licensees." The Department still has not adopted regulations for this purpose.
- In the 2002 case of the *Committee to Bridge the Gap, et al, vs. Bonta, et al.* (Case No. 01CS01445), the Sacramento Superior Court overturned the DHS' adoption of lax radiological standards for decommissioned sites—standards which had been used by the DHS to justify sending decommissioning wastes to municipal landfills.
- In 2004, Senator Romero, Chair of the Select Committee on Urban Landfills, released a report on radiation levels at California landfills and underground water supplies that shows at 22 of the 50 California sites tested, elevated radioactivity was detected in leachate and or groundwater.
- Senate Bill 2065 (Kuehl), Statutes of 2002, requires the Department to maintain a tracking system for LLRW. However, it still has not been implemented. The Department *estimates* that it will be done in July 2007; however, it is unclear as to what information will be available at this time. Implementation of the legislation is needed for tracking shipments of waste, accountability throughout the system, source reduction, and projecting future waste streams.
- A March 28, 2007 letter sent from certain employees within the DPH to the Capital Weekly Group, with copies shared with Member's offices (see Hand Out), also raises questions as to the management of the program within the DPH.
- The DPH states that existing licenses for radioactive materials would have to be amended to allow for the long-term storage of LLRW. They note that these amendments would

need to be done on a "case-by-case" basis, as each licensee contacts the DPH with respect to an increase in their possession limit. However, the DPH then states that many licensees have possession limits that are already higher than the material they actually possess, so an immediate amendment to accommodate long-term storage would not be necessary. So how is long-term storage of LLRW really being monitored?

Background—Relationship Between the DPH and the Department of Toxics & Substance Control. The Department of Toxics &Substance Control (DTSC) protects public health and the environment by: **(1)** regulating hazardous waste management activities; **(2)** overseeing and performing cleanup activities at sites contaminated with hazardous substances; **(3)** encouraging pollution prevention and the development of environmentally protective technologies, and **(4)** providing regulatory assistance and public education.

The DTSC does *not* have jurisdiction over the control of ionizing radiation. When the DTSC regulatory activities involve a site and radiation issues are raised they contact the DPH's Radiologic Health Branch for assistance. The Radiologic Health Branch is to support the work of the DTSC by including the review of site histories, survey data, and other relevant information, and the collection of samples, analyses of samples and other survey or sampling activities as needed.

In addition, the DPH's Division of Drinking Water and Environmental Management provides two dedicated Health Physicists directly to the DTSC to review radiation issues involved in the clean-up of formerly used Department of Defense sites.

The Administration states that the DPH (Radiologic Health Branch and Division of Drinking Water), in coordination with the DTSC, will recommend remedial action as necessary.

Senate Bill 2065 (Kuehl), Statutes of 2002: Low-Level Radioactive Waste (LLRW) Tracking System. This legislation was the product of a blue panel Advisory Group on Low-Level Radioactive Waste in 1999. This Advisory Group recommended that California institute an annual survey of waste generators and receive notification of all LLRW shipments.

Among other things, SB 2065 directs the DPH to conduct an annual inventory of California's 2000 plus licensed LLRW generators. They must record how much and what kinds of LLRW are produced, as well as the transport, storage, treatment, disposal or other disposition of this waste. In addition, it requires that a copy of the shipping manifest accompanying each waste shipment for disposal be forwarded immediately to the state. All other toxic waste industries are required to report annually on the production and disposition of their wastes.

Currently, no state agency has comprehensive real time information that would enable them to track shipments or storage of LLRW. Radioactive materials and waste are also very vulnerable to theft and sabotage during transport. Implementation of the legislation is needed for tracking shipments of waste, accountability throughout the system, source reduction, and projecting future waste streams.

Subcommittee Staff Recommendation. As part of the overall restructuring of the Department of Health Services into a separate Department of Public Health, Governor Schwarzenegger stated that he was going to convene a work group of Cabinet Secretaries to develop the next steps on consolidation and re-organization of other public health related and/or health purchasing functions within state government.

It is clear that strong consideration should be given to moving Low-Level Radioactive Waste responsibilities regarding the regulation of the use, handling, transport and disposal of ionizing radiation from the Department of Public Health to the Department of Toxic Substance Control within the California Environmental Protection Agency.

Therefore, it is recommended to adopt the following trailer bill language.

> **"**The California Health and Human Services Agency and the California Environmental Protection Agency shall confer to develop a specific transition plan for the transfer of the responsibilities regarding the regulation of the use, handling, transport and disposal of ionizing radiation from the Department of Public Health to the Department of Toxic Substance Control or other applicable entity within the purview of the California Environmental Protection Agency. This transition plan shall be provided to the policy and fiscal committees of the Legislature by no later than November 1, 2007. It is the Legislature's intent to transfer and strengthen the regulation of radioactive materials in order to ensure greater public health and environmental protection.**"**

Questions. The Subcommittee has requested the CA Health and Human Services Agency (CHHS Agency) to respond to the following questions.

1. **CHHS Agency**, Please comment on the proposed trailer bill language.

LAST PAGE OF AGENDA